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EUROPEAN NETWORK FOR CHILDREN AFFECTED BY RISKY ENVIRONMENTS WITHIN THE FAMILY

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Domestic Violence and Abuse experienced by Children and Young People living in Families with Alcohol Problems

Results from a Cross-European Study

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1.1 The problem and how it was tackled

1.1.1 Children and young people living in families where parents have significant problems with alcohol are often very badly affected. They have a range of very negative experiences, and often develop problems and psychological and/or physical symptoms as a result.

1.1.2 Similarly, children and young people growing up in families where there are significant problems with domestic violence or aggression are also often badly affected: they also often experience a range of distressing incidents, and also often develop problems of their own as a result.

1.1.3 It is well known that the incidence of domestic violence and aggression is much higher in families where there are also alcohol problems; but very little research has been undertaken on the impact of both of these family problems on children and young people.

1.1.4 Although many children and young people do develop problems as a result of both of these family upbringings, a significant minority do not. They seem to be resilient.

1.1.5 This project set out to look at children and young people across Europe, to discover what impacts having parents with both of these problems combined had on children, and then to suggest ways of improving practice and policy, within individual countries and across the EU, that would help these children.

1.1.6 Experts in issues relating to addiction or violence within the family from eleven institutions located within ten EU states participated in planning and overseeing this project: Germany, where experts also co-ordinated the project, and Austria, England, Finland, Hungary, Ireland, Malta, Netherlands, Poland and Spain.

1.1.7 57 children and young people between the ages of 12 and 18 years were recruited into this project and interviewed, from Germany (27), England (8), Malta (3), Poland (13) and Spain (6). A further 13 children and young people were recruited in Germany as comparison cases. The data were collected by using a very detailed interview which interwove standardised quantitative measures with open, qualitative questioning. The data from these 57 children and young people were examined very closely, and 12 of them were subsequently excluded from the quantitative analyses (6 from Germany, 3 from England, 3 from Poland), due to concerns that the alcohol problem was not current within the previous 12 months. The final data set reported on consists of 45 children and young people with parents with serious alcohol problems. The project

decided to use a new term to describe these children: Children Affected by Parental Alcohol Problems (ChAPAPs).

1.1.8 These children and young people report having lived under considerable **stress** for often long periods, having to deal with family and parental environments where there was serious alcohol misuse, and serious domestic abuse, frequently moving into family violence. They also reported signs of considerable **strain**: quite considerable numbers (36% of the sample) reached borderline or Clinical levels of problem on the Youth Self Report Scale, and many (29%) also have had contact with Mental Health services, either currently or in the past. They report using a wide range of **coping** strategies and tactics, and frequently use coping strategies which are the most effective ones, such as seeking social support, trying to sort the problem out as well as they could, distracting themselves and trying to control their feelings. Some less effective coping strategies were also used, especially wishful thinking. However, in general, young people found it terribly difficult to cope in very helpful ways, and often were left feeling extremely angry, frustrated, and very sad. There were a wide range of people from whom these young people gained **support**, mainly family and friends. Nevertheless, most young people were able to tell us about ways in which they could have been offered more support in the past, and how that would have been extremely helpful and might have made coping with these problems a little better. It is also clear that, although many children did and do suffer considerable strain, others have been able to become or remain **resilient**. It is vital that a better understanding is gained of the processes which allowed that to occur.

1.2 Existing Policy Responses within Europe

1.2.1 The existing policy response across the different EU countries, and across the EU as a whole, to the problems which beset children, young people and families in situations where there is co-existing alcohol misuse and domestic abuse within the home environment is poor. One of the most important findings of this component of the current project was that when each of the ten partner countries was asked to attempt to locate (and if so provide examples of) policies (however the term 'policy' was defined) in relation to addressing both alcohol misuse and domestic abuse within the family, this proved to be a problematic exercise. What emerged from this relatively 'random snapshot' is that in all of the partner countries, and on many levels, these two problems (alcohol misuse, domestic abuse) are still dealt with separately. It is also the case that, in many of the partner countries, the separate policies relating to alcohol or violence do not focus sufficiently upon the family and the effects of the issue (alcohol, violence) on the family as a whole and on its individual members.

1.2.2 One of the problems across Europe is the lack of collaboration between the different organisations involved. In many countries there are (or are soon to be) in existence national alcohol policies, but these do not make policy statements about the co-existence of alcohol misuse and domestic abuse. In other countries there are policies and sets of laws about violence in the family (and there are often other mentions of family violence as well), but these do not mention alcohol problems or misuse at all; and the proposal in Hungary to develop an alcohol policy barely mentions family aggression and violence.

1.2.3 Occasionally there are good practice guidelines for working with 'survivors and/or perpetrators of domestic violence who also use alcohol and drugs', where the guidelines address the issue of domestic violence and how best to work with survivors and/or perpetrators who are also using drugs and alcohol. Such guidance is aimed at all those working with the issues of domestic violence and substance use and aims to inform and improve practice; but such guidelines are not policy statements as such, and do not lay out goals to be evaluated or set out prescribed action plans.

1.2.4 Given the lack of a coherent alcohol policy in any of the EU member states from which project partners participated, it is not surprising that there is also no sign of a coherent policy within the EU as a whole, linking alcohol misuse and domestic abuse.

1.3 Problems in conducting the project

1.3.1 This was an extremely difficult project to undertake, for a number of reasons, mainly related to the fact that these children are 'hidden' (because of the shame and fear associated with both parental alcohol problems and domestic abuse). It is very difficult therefore to reach them with empirical social research methods. Whilst it is acknowledged that this sample is inevitably biased, nonetheless the data collected offer an invaluable insight into the lives of this sample of young people. Further, the experience of undertaking the research has been invaluable learning for conducting other, similar, research, including accessing young people in other ways, especially where a parent may not be currently accessing help for their alcohol problem, and particularly where young people might be able to be accessed because of their experience of parental violence or abuse.

1.3.2 One key area where problems occurred was in relation to ethical approval and issues of consent, where it emerged that very different regimes exist across the different European countries. Clarifying and standardising these procedures across Europe would greatly assist future research of this type.

1.4 Implications for policy and practice

1.4.1 The children and young people told us that they had rarely been offered help in their own right to deal with their parental alcohol misuse problems and domestic abuse.

1.4.2 It is clear that a variety of solutions and improvements are needed. But whose job is it to respond? We contend that it is all of ours:

- Government (via policy directives, service commissioning and resource allocation)
- Professionals/service providers (all health, social care, criminal justice and other front-line professionals to identify and intervene)
- Professional education
- Communities/public

This poses considerable challenges, at all of the policy, professional and services levels.

1.4.3 In terms of policy, there are many issues:

- At the International level, there is no co-ordinated approach to tackling the interrelationships between parental alcohol misuse and domestic abuse.
- It is also the case that the regulatory regimes concerning (for example) ethical approval, or parental consent for undertaking research with minors, are very different in the different EU countries. A greater level of co-ordination and standardisation of these procedures across Europe would greatly assist future research of this type.
- At the National level, in all of the 10 EU countries represented in this project, there still exist separate policy bases for substance misuse and domestic abuse, and in some countries there exists an equally large division between policy frameworks relating to alcohol and to drug problems. There is very little acknowledgement of the overlaps between these issues. The family is often absent from all of these sets of policies.
- It is also the case that National policy directives lead commissioners to commission these various services (which ought to be very interlinked) separately: hence there are few linkages between alcohol or drugs or domestic abuse services, or between children's or adults' services; and the family (as opposed to individuals who drink alcohol or use drugs or perpetrate abuse) is often absent from all of these services.
- Related to this, the structural separation of adult and children's services implies a lack of listening to the needs and wishes of families, nor to facilitate joint working.
- At the Agency level, again there are very few policies and procedures in place; and there is some evidence that, if they do exist, they are not followed. Similarly, there is a lack of monitoring in order to provide an evidence-base on which to develop services.

1.4.4 There are many challenges at the professional and service level too. Some of the key solutions include:

- ChAPAPs need greater public and professional attention and support.
- The present knowledge (e.g. concerning risk and protective factors) must be applied, and be applied sufficiently early.
- Much more research needs to be undertaken on these related topics.
- The prevention and treatment approaches developed so far should be evaluated and in cases where there is good evidence, introduced to all EU-25 countries.
- There must be a solid and secure basis to finance prevention and intervention with ChAPAPs.
- The interventions must happen early, in a comprehensive and coordinated manner, they must be family-oriented, and must contain both addiction-specific and unspecific elements.
- General experts (GPs, teachers, child protection services) must be informed and trained for the special situation and needs of ChAPAPs.
- The resources of communities as sources of support should be explored.
- New community-based interventions should be developed.
- Communities need to be activated, to pay attention to these problems of alcohol misuse and domestic abuse, and to respond.

- Children also report that talking to others who have had the same or similar experiences or problems in their families is helpful. They seem to find if helpful to realise that they are not alone. There are clear implications here about improving access to existing and future groups which are created for ChAPAPs, and about supporting these groups and making them better known.
- The development and production of comprehensive guidelines outlining well-coordinated, evidence-based help and support for ChAPAPs.
- The manualisation of basic approaches (easy to apply, e.g. for nursery/kindergarten, single case work, schools, promotion of parental capacity, etc.)
- Better and clearer regulations for financing work with ChAPAPs
- Strengthening public awareness and continuous education of experts (general and specific)
- Broadening early intervention through better networking of institutions, and strengthening ways of early detection (including motivational interviewing with parents)

1.4.5 We suggest that the future should include significant movement at the level of Policy:

- **International level** – there is an urgent need for the European Commission and WHO Europe to develop and issue International guidance on the issue of the co-existence of alcohol and domestic abuse problems, and on how best to deal with these problems.
- **National level** – at this level there needs to be policy recognition of the overlap in all of their documents, including ones relating to children, substance use and domestic abuse, recognition of impact, and need to respond.
- **Agency level** – monitoring of both issues and co-existence; policies and procedures in place to support staff and service users

1.4.6 The future needs also to consider Services …

- Services need to respond more holistically – a single focus does not address complex needs
- Services need to join together to provide one single service or to develop formal and active partnerships with each other at all levels of the organisations, e.g. management and front-line staff
- It seems clear that systems that separate adult and children services are not helpful for families – there is a need to change this structures, or to designate mandated partnership working with shared goals.
- Partnership working between substance misuse and domestic abuse agencies is vital. In these partnerships it is imperative to:
    - Focus on similarities of models of working and how to overcome any barriers
    - Learn about, and respect, each other's priorities; devise a way of working together that will do this
    - Share specialist information and set up training exchanges to support learning and confidence in working with the 'other' issues
    - Joint working - agree confidentiality protocols; ensure clear lines of accountability to help continuity if staff leave, ongoing cross agency communication and mutual support to foster trust and respect

- Similarly, practice guidance is essential - clear practice guidance on how to assess for other issues, with a clear discussion on how to respond (including impact on children), when to refer on and how, how to record, who to consult with etc.
- There also needs to be clarity that dealing with co-existing domestic abuse and parental alcohol problems it is part of doing one's own job well: it is not always somebody else's job!
- In order to facilitate all of this above, managers and supervisors need training on all issues and an awareness of the impact on staff; and they need to take leadership on the policy and on practice development.

1.4.7 … And the Community

- The community and the general public must share the responsibility for intervening when alcohol misuse and domestic abuse are observed.
- The resources of communities as sources of support need to be explored and mobilised.
- New community-based interventions must be developed.
- Communities need to be activated, to pay attention to these problems of alcohol misuse and domestic abuse, and to respond.

1.5 Conclusions

The results from this two-year project of research and practice show how important it is to develop guidelines to advance the practice of prevention and intervention in the area of alcohol and violence problems within the family. It is also vital that all political decisions, especially in the health, social and safety areas, must be made taking into account the child's perspective. Some suggestions for what these guidelines should include are:

- Treatment facilities for alcohol, drug or violence problems should be obliged to find out whether their clients have children, whether the children currently reside with the parent undergoing treatment and to what extent there have been any instances of violence in their previous history.
- In cases of need, the pertinent institutions should be in a position to offer family-related support or at least to provide information on it and to offer a specific parenting skills' programme.
- Even if the professionals cannot successfully address the parents' addiction problem, there should be sufficient opportunities for support and assistance available.
- Appropriate awareness must be developed by a wide range of professionals: help and support strategies are better than ignorance and neglect.
- The institutions involved must work together better and, with the consent of the families, must develop and co-ordinate the implementation of assistance and support programmes. There need to be agreed information sharing protocols, and agreed methods of joint working, within each European country.

The four key points as to how professionals can help families are:

- It is relatively clear how professionals can help to modify the impact of parental substance misuse on children: they should help them to reduce risk, develop protective factors and promote resilience

- Practitioners CAN intervene, and the focus does not have to be on the substance misuse, but on providing necessary beneficial factors in children's lives
- Practitioners must not be sidetracked into focusing on the parents' problems: the focus must be on the child's needs and how to meet them
- The problem is, not enough practitioners actually DO this! Further work is needed to encourage and train professionals to use this knowledge to work in a more focused and integrated way, looking at the full range of a child's needs within a broader context.

It is to be hoped that the work within the ENCARE project is one way that will encourage practitioners to do this, and take on more responsibility for promoting resilience.

2 The ALC-VIOL Project and the ENCARE Group

2.1 The Goals of this Project

The ALC-VIOL (Violence, Accidents and Injuries experienced by Children and Young People living in Families with Alcohol Problems) research project was concerned with domestic violence and abuse experienced by children and young people living in families with alcohol problems. The project had three main aims. First, it provided a rare and valuable opportunity to talk to children and young people (aged between 12 and 18), in several European countries, about their experiences of living with parental alcohol misuse and parental violence. We wished to hear from young people what it was like for them to live in an environment where both of these parental problems were present. Second, ALC-VIOL also aimed to use the data gathered from these interviews with children and young people to offer guidance on the development of intervention and prevention strategies for supporting these young people. Third, we wished to examine different countries' policy positions on co-existing alcohol problems and domestic abuse within the family. Finally, given that these issues are not adequately prioritised across Europe, ALC-VIOL aimed to make a significant contribution by developing and strengthening National Networks of specialists in these areas (alcohol misuse, violence) so that they could raise awareness of the issues of parental alcohol misuse and parental violence, and of the needs of children living in such circumstances.

2.2 ENCARE

The ALC-VIOL project is part of a wider group of projects, under the overall ENCARE group (the European Network for Children Affected by Risky Environments within the family). In 2002, 13 EU countries collaborated in the first ENCARE project, funded for two years by the EU Public Health Directorate, and coordinated by the Catholic University of Applied Sciences North-Rhine Westphalia, Cologne, directed by Professor Dr Michael Klein. ENCARE was founded to help professionals tackle the problems faced by children who live in risky family environments. The risky family environment we considered in this first project was one where parents had problems with alcohol. This first project set up the ENCARE network within Europe, started the development of national networks of professionals who were concerned with children affected by such risky family environments, and developed a website (www.encare.info) where information and tools were placed which would help professionals who come into contact with or work with children living in families where a parent has an alcohol problem. The project could only fund a website in one language (English) and so it was decided to concentrate the site on material useful for professionals: we stated on the site that children and families might also find some useful information on the website, but we suggested that they may also want to make contact with organisations in their own country, where materials would be in their natural languages. The project also developed a new terminology for the children in this environment. These children are often referred to as Children of Alcoholics (COAs). However, it was considered that using this term was potentially stigmatising, and some partner organisations were unhappy with the term COA, feeling that this might exclude many children negatively affected by parental drinking whose parents did not meet strict diagnostic criteria, so we developed the term ChAPAPs (Children Affected by Parental Alcohol

Problems), which is intended as an alternative (and more widely usable) term. It is the term we use in this Report.

The first ENCARE project finished in 2004. Since that time the European network has continued and developed, and there have been other EU-wide projects: the Daphne-funded[i] ALC-VIOL project which is the subject of this Report, and other projects such as TAVIM[ii] and CHALVI[iii], funded by the Daphne programme, as well as a new project, ChAPAPs[iv], funded by the EU Health and Consumer Protection Directorate General (2006 Public Health programme). All of these different projects are intended, within the wider ENCARE programme of work, to develop and strengthen the sensitivity and awareness of professionals working in either addiction or young people's welfare services, about these hidden or disregarded problems of children and young people in families with alcohol and addiction problems.

Across Europe, the present culture is one of lack of awareness or ignorance about these issues; the ALC-VIOL project aimed to encourage professionals to look more closely at the needs of children where parents had both of these problems, and to ensure that every professional takes responsibility for the welfare of children, even if the professional is primarily focused on work with an adult substance misuser.

3 Parental Alcohol Problems, Parental Violence, and Children

What follows below is a brief review of some of the key literature, in order to provide a context, enabling understanding of the nature and extent of the difficulties for children in families where parents have co-existing problems with both alcohol and domestic violence.

In fact, there has been considerable published research (from across Europe as well as the wider world) in the area of

- the effects on children who live with one or more parents who have serious substance misuse problems (e.g. Christensen, 1995, 2000; Cleaver, Nicholson, Tarr, & Cleaver, 2006; Cleaver, Unell & Aldgate, 1999; Forrester & Harwin, 2006; Gorin, 2004; Hinze & Jost, 2006; Kemmner, Klein & Zemlin, 2004; Klein, 2005; Klein, Ferrari & Kürschner, 2003; Klein & Zobel, 2001; Lieb, Merikangas, Hoefler et al, 2002; Templeton, Zohhadi, Galvani & Velleman, 2006; Velleman, 2004; Velleman & Orford, 1999; Velleman & Templeton, 2007),
- and also the effects on children if they live in a household where there is significant domestic violence (e.g. Cleaver et al, 1999, 2006; Coleman, Jannson, Kaiza & Reed, 2007; Fergusson & Horwood, 1998; Gorin, 2004; Hester, Pearson & Harwin, 2000; Kindler, 2002; Klein & Zobel, 2001; Mullender, Hague & Imam et al, 2002).
- There is also some research on the additional risks involved if children live with both of these problems simultaneously (e.g. Cleaver et al, 1999, 2006; Fergusson & Horwood, 1998; Galvani, 2004, 2006, 2007a, b; Gorin, 2004; Hester et al, 2000; Irons & Schneider, 1997; Kemmner, Klein & Zemlin, 2004; Kindler, 2002; Mullender et al , 2002; Templeton, Zohhadi, Galvani & Velleman, 2006; Velleman & Orford, 1999).
- There is also research which examines in more detail risk and protective factors, and resilience (Rutter, 2006; Schoon, 2006; Velleman & Orford, 1999; Velleman & Templeton, 2006, 2007).

This section of the Report will briefly review the main effects of both these risk factors separately, and of them together. It will then look at risk and protective factors, and at resilience, before examining what these data tell us about children's needs. References corroborating all of the statements below are listed above and at placed in full the end of this Report.

3.1 Family Substance Misuse

Substance misuse problems commonly have a wide range of effects on the family and on family functioning. In brief, some of the main impacts of living in a family where someone misuses alcohol or drugs are that:

- Family members often suffer many *negative experiences*, including violence, poverty, and social isolation.
- Family members, as well as the person misusing substances, will often *develop problems* as a result of these and other experiences.
- Some will be *individual problems* (such as anxiety and depression).

- Others will be *family problems* (such as breakdowns in such family structures and systems as rituals, roles, routines, communication structures, social life and finances).
- *Children often have particular difficulties*, demonstrating whilst still young a higher propensity for anti-social behaviour, emotional problems, and problems in the school environment, and during adolescence often showing friendship difficulties, a division between home life and peer relationships, being prescribed psychoactive drugs, earlier use of alcohol or drugs, leaving home early, earlier marriages and involvement with a 'semi-deviant' sub-culture.

It is also the case that the numbers of children likely to be affected by parental substance misuse are huge. Just looking at alcohol problems, in terms of children and young people under the age of 18, one study in Spain estimated that “children of alcoholics” constitute 11% of the overall population; it has been estimated that in the UK there are between 780,000 and 1.3 million children affected by parental alcohol problems; and in Germany that there are approximately 2.65 million children of parents with alcohol abuse and dependence (life time prevalence). Across the EU, it was estimated in the late 1990s that there were between 4.5 and 7.7 million children under 15 years of age affected in the 15 EU countries plus Norway (i.e. between 6.8 -11.7% of the overall population of around 60 million children across these countries under 15 years of age at the time); and that there are between 10 and 12 million ChAPAPs in the EU-25.

3.2 Family Violence

Some of the main findings of research which has looked at the impact of living in a family where domestic violence is rife are that, in brief, the impact of domestic violence is very similar to that of substance misuse: there are commonly effects on

- parenting skills,
- parents’ perceptions of themselves and of the outside world,
- their attachment to their children and vice versa,
- their control of their emotions,
- and their attention to or neglect of their own and their children’s physical needs.

There is a similar range of social consequences too: there are frequently

- effects on the family’s living standards,
- a loss of contact with friends and family,
- and a disruption to family relationships.

Again, the numbers involved are very large. It has been suggested that, in the UK, nearly 2 women are killed each week by a partner or ex-partner, and that women with children are at more risk than women without children. It has been shown that clear links exist between perpetrating adult domestic abuse and child abuse, and that many children report witnessing, and often experiencing, extreme violence. In fact, research shows that 90% of children are in the same or next room at the time of the violence and abuse, and more than 50% of children are the direct victims of domestic abuse.

3.3 Living with both Family Violence and Family Substance Misuse

The effects on children and families where alcohol problems or domestic violence exist as separate entities are very large. Unfortunately, these two family problems often co-exist. Alcohol and/or drug problems are often both present where there is domestic abuse, and when they do co-exist, the substance misuse has been found to increase the frequency of domestic abuse, with the substance misuse being associated with an increased severity of injuries inflicted. In studies of men in treatment for their substance misuse, around 50% admitted perpetrated domestic abuse within the previous 6-12 months.

It is very clear that, as **separate** issues, parental alcohol problems and domestic abuse very often have very negative impacts on both parenting skills and capacity, and children's health and well-being. Children in households with either of these problems are at much increased risk of all forms of abuse, and they also very often live in fear, feeling guilty, feeling responsible, being socially isolated, having emotional and behavioural problems, and being forced to accept inappropriate age roles (such as being a carer for an intoxicated or an injured parent). It is also very clear that a child living with **both** the problems of parental alcohol difficulties and domestic abuse has the harm compounded.

The research, therefore, shows that substance misuse and violence in the family can have very detrimental effects both on parents and on children, and that in combination, the effects are even further compounded.

3.4 Risk and Protective Factors

There are also a number of issues which serve to increase the risks and increase the likelihood of any negative effects on children, and others which serve to protect children or make them resilient.

3.4.1 Risk Factors

The factors that exacerbate risk when one or both parents have substance misuse problems include domestic abuse (as outlined above – both violence and exposure to marital and family conflict), parental separation and loss, inconsistency in parenting, ambivalent parenting, both parents misusing substances, the drinking or other substance misuse occurring within the family home, and high levels of family disharmony.

Similarly, the research into the impact of domestic violence on children and families has shown that the impact is more likely to have a detrimental effect on the children if they themselves are targets for parental aggression (or rejection); if they witness the violence between their parents; if they are drawn into the violence (e.g. by trying to protect one parent from the other one); if they are drawn into colluding with concealing the assaults; or if the domestic violence is combined with alcohol or drug misuse (again, as outlined above).

3.4.2 Protective Factors

The protective factors include the provision of stability, time and attention from at least one parent, the presence of a cohesive parental relationship with overt parental affection, the retention of a cohesive set of family relationships involving shared family activities and shared family affection, the ability of the child(ren)

to disengage from the disruptive elements of their family lives, and the presence of significant external support systems which provide the stability which may be absent from their normal family life.

Again, there is a similar range of protective factors in the research literature on domestic violence: adverse effects on children are less likely when parental problems are not associated with family discord and disorganisation; do not result in the family breaking up; when the other parent or another family member can respond to the child's developmental needs for security and love.

These protective traits are all fostered by secure, stable and affectionate relationships and experiences of success and achievement. There are also 'internal' protective factors which children may demonstrate, relating to their inner resources such as a positive sense of self esteem and self confidence, a feeling of being in control and capable of dealing with change, and the development of a range of approaches for solving problems. These protective factors all assist the child.

3.4.3 Resilience

There is increasing interest across the world in 'resilience', both generally and with respect to parental substance misuse. Until recently it had been assumed that parental substance misuse could only impact negatively on children, both in the short- and the long-term. Protective factors, it was thought, might reduce the harm experienced but there would still always be negative consequences. However, evidence of a rather different pattern of impact of these problems has started to emerge: it seems that some children are resilient and do not develop significant problems, or do not develop problems at any different rate to children in non-substance misusing families, either when they are young or when they reach adulthood and perhaps have families of their own. This suggests that all children do not need further help and support; and this implies that it becomes even more imperative to develop better ways of screening those children who have developed or are developing problems, so that effective and timely help can be selectively given to those who need it.

Resilience can be seen in terms of a number of identified protective factors and processes, which if present can serve to benefit the child or young person. Some of these protective factors were outlined in the previous section, and they include high self-esteem and confidence, self-efficacy, an ability to deal with change, a good range of problem solving skills, and previous experience of success and achievement, as well as being raised in a small family, larger age gaps between siblings, low separation from the primary carer in the first year of life, close positive bond with at least one adult in a caring role (include parents, siblings and grandparents), a good support network beyond this, and engagement in a range of activities. Protective processes include any reduction of the impact of the risk (altering the risk or changing the exposure), reduction of negative chain reactions, development and maintenance of self-esteem and self-efficacy, and the presence of opportunities, as well as individual temperament, skills and values that lead to a more efficient use of the child's personal ability, the characteristics and care style of a child's parents, support adults, and positive opportunities at times of life transition. How resilience can be promoted and can operate at key transitional points in life or at key developmental stages is important. This is especially the case with

children exposed to multiple risks within their family environment, such as both substance misuse and domestic abuse.

3.5 Children's needs

Children and young people in families where there are alcohol or drug problems tend to have a significant exposure to most of the risk factors outlined above, and often do not receive exposure to many protective factors. They are a particularly high-risk group for all types of violence, as has been shown in much international research. This includes physical, emotional and verbal abuse, and may involve the violence being aimed at them, or may involve the young people witnessing such violence between their parents or other family members. In individual European countries rates of such abuse aimed at children and young people by the father or mother whilst under the influence of alcohol are reported to be just over 50%.

These children have a wide range of needs but, despite the high numbers of children living in these risky family environments across Europe, very few attempts have been made to talk directly to young people about their experiences, their needs and how these needs could be met. There is much that can be done to help these children and their families, irrespective of whether the parent(s) seek support for the substance misuse and the violence, making it imperative, therefore, that these children are identified as early as possible and that help is instigated as early as possible, and maintained for as long as is necessary. (This of course does not mean that all ChAPAPs will need referral for therapy, just that they are both 'at risk' and usually hidden; and hence early identification would allow for an assessment of what their actual needs were.) However, across Europe, there is a dearth of targeted support available for these children, their families and the broad range of professional groups who work with or come into contact with children living with parental alcohol misuse and/or parental violence.

The ALC-VIOL project, then, was designed to collect information from children and young people from across Europe, to provide data to support a greater level of interest and involvement from the range of professionals across Europe who work with or come into contact with children living with parental alcohol misuse and/or parental violence, so that targeted support for these children and their families can be increased.

4 The ALC-VIOL study - Domestic Violence and Abuse experienced by Children and Young People living in Families with Alcohol Problems

4.1 Participating EU countries

Experts from eleven institutions (Listed in Appendix 1) located within ten EU states took part in the Daphne funded two-year ALC-VIOL project. The countries represented were Germany (project leader and co-ordinator), Austria, England, Finland, Hungary, Ireland, Malta, the Netherlands, Poland and Spain. All those participating in the project were experts in issues relating to addiction or violence within the family and their coming together was highly productive and constructive.

4.2 Methods

4.2.1 Recruitment

As the children affected usually live in extreme isolation and those in their immediate environment generally do not know about their situation, it is very difficult to reach them with empirical social research methods, and there are many challenges inherent in conducting research in this area. Specifically, there is understandable wariness from services, and from parents who do not wish their children to discuss what has been going on at home and fear further involvement with or reprisal from social or child-welfare services.

Therefore, it was decided to access children and young people in cases where a parent's alcohol problem was already know. This was **primarily via a parent who was actively engaged in treatment for their alcohol problem** but also included cases where **a child was in contact with a specialised service**, where screening might show that a parent's alcohol problem was involved with the child's case. A variety of other methods was also attempted (such as via shelters for women and children escaping domestic abuse, where it was thought that many cases would also be alcohol-related), although no children were successfully recruited from these sources. Recruiting from the sources that we did use meant that the parents who were approached to give consent had usually already accepted that they had an alcohol problem and often were or had been actively seeking to do something about it. It was hoped that this would reduce the concerns that the parents would have about information their children provided leading to new and extra child protection concerns. However, because we were recruiting children where the alcohol problem and/or the domestic abuse was already known and hence was starting to be dealt with, this decision also meant that the project would recruit very few children for whom the problems were as serious as they were before they entered treatment. The sample investigated therefore was not representative of the entire group of ChAPAPs. This is further discussed towards the end of this Report.

Project partners in each of the countries involved sought ethical approval for the research (see section 4.2.3 below) and approached alcohol treatment and other services in their regions or countries. Due to the perception by treatment services and ethical committees that questioning young people aged 12-18 about their parents' drinking and any family violence would be highly sensitive, many services refused to

participate, or, if they agreed, then found that they could not recruit many parents (through whom access to the children was to be obtained), or found that they could not recruit many children who met the inclusion criteria (of both living with their parent over the past year and their parent having drank problematically over the past year, see 4.2.2, below). A further obstacle for services who wished to help in the recruitment for this project was one of workload: because they often did not have the relevant information in their files (such as whether the drinker lived with their children, how many children they had, how old were they, are they in contact with their children, etc), gathering this information was time consuming. Yet another problem was that, when attempting to access children via parents in treatment for their alcohol problem, many clinicians were concerned that these parents were at a difficult stage within their treatment and did not wish to potentially disrupt things by asking about their children and raising the issue of the impact of their behaviour on these children. Again, these issues are further discussed towards the end of this Report. Section 4.3 below outlines the numbers of young people who were recruited and interviewed from each country.

Once approvals had been granted, each service which had agreed to participate then attempted to recruit into the project. In services where the recruitment was undertaken via the parents, those parents who were (or had been) in contact with the service, who had children in the 12-18 age range were approached; those who agreed to hear more then had the project explained to them; those who met our inclusion criteria (see previous paragraph) and who agreed to help the project then asked their child(ren) if they would participate; and those children who showed potential interest then received their own invitation to participate with child-friendly information on the project and what the interview would contain. In the case of children who were approached because they were themselves being treated, these children's parents were approached and informed about the project; and the same process as outlined above was gone through. Children who agreed to participate were then contacted by a researcher from the participating project partner organisation. Throughout each stage it was emphasised to those who were recruiting parents (and then children) that it was imperative to be flexible, that screening to ascertain parental problems could take place in a variety of ways and settings, and that the project was independent from the treatment or other setting from which the parents and / or children were being recruited. There was, however, considerable drop-out at each stage of this procedure.

A comparison sample was also recruited, in order to be able to compare some of the main questionnaire results with results from children who did not have these experiences. Because we knew that our main interest was in the ChAPAPs group, we decided to recruit only a small a comparison group.

The recruitment settings for each of the participating countries were as follows:
England: a collaboration with a National Health Service alcohol treatment agency near to the project partner's University base. Additional funds were obtained in England to pay for clinician time in this service to aid recruitment. Two of the interviews were conducted at that service; the others were conducted in the participant's home.
Germany: Recruitment from alcohol withdrawal clinics all over Germany (which yielded the majority of cases successfully recruited), out-patient alcohol/addiction counselling services, and self-help groups for ChAPAPs. Interviews were conducted in each recruitment setting.

Germany Comparison sample: From schools in Cologne (young persons had taken part in a representative questionnaire epidemiological study on substance abuse), interviews were conducted at home or at the project coordinator's institution.

Malta: The young people were recruited from a private alcohol treatment clinic where their parents had been treated, Interviews were conducted in the recruitment setting.

Spain: Young persons were recruited via parents from the out-patients treatment component of a local hospital Alcohol Unit. Given that the out-patients programme is two years long, and the inclusion criterion of 6 months active drinking within the previous 12 months, this reduced the numbers who were able to participate. Interviews were conducted in the recruitment setting.

Poland: Recruitment from a therapeutic day centre for children (which yielded the largest number of cases successfully recruited), a crisis intervention centre, an alcohol dependency centre and a hospital clinic. Interviews were conducted in each recruitment setting.

Two other countries did hope to be able to participate but in the end could not:

Hungary: Eventually (after a very long time) managed to obtain ethical approval, then attempted recruitment, but did not manage to interview. They undertook one pilot interview (recruited via a community alcohol service), and approached 3 further families (from a new project, a co-operation between family social care and a child protection service) but were unable to undertake any interviews with young people before the end of the project .

Finland: Also attempted to recruit, using two institutions in Finland, but were unable to undertake any interviews.

The three other countries within this project (**Austria, Ireland, Netherlands**) decided that they would be unable to recruit parents from treatment services and through them, recruit young people (for various reasons, including the partner being a prevention agency and not a treatment or solely a research one; and to the barriers being put up by treatment agencies or ethical committees). Some of the barriers and issues arising from them are all discussed further in Chapter 7.2. All the countries who did not recruit young people still participated in the other aspects of the project (development of guidance, examination of policy, development of national networks) and in the overall steering of this component.

4.2.2 Research questions and Inclusion criteria

There were five main research questions:

1. What is the nature of family conflicts, domestic violence and injuries and accidents experienced by young persons in families where there a parental alcohol problems?
2. In families where there are parental alcohol problems, does (direct or indirect) parental physical violence put young persons at increased risk for experiencing psychological and conduct problems?
3. How do young persons cope with the co-existence of domestic violence and parental alcohol problems?
4. In families where there are parental physical violence and parental alcohol problems, do children and young people feel that their support needs are met? Which types of social support exist? Do children and young people display resilience?

There were five inclusion criteria:

A. At least one parent (or parental figure, such as a step-parent etc.) has a significant known alcohol problem. (For recruitment purposes, we had to rely on information from the co-operating institution about the parental alcohol problem, but this was also checked in the interview). The parent can but does not have to be currently in treatment for their alcohol problem; if they are not currently in treatment, then the parental alcohol problem is assessed in more detail during the interview.

B. Affected parent has no severe mental disorder, i.e. schizophrenic disorder with incomplete remission or severe mood/affective disorder. The affected parent is allowed to have other mental health difficulties (e.g. personality disorders or anxiety disorders): the determining factor is that the mental disorder is not the main problem: the main problem must be the alcohol one.

C. Affected parent has a child between 12-18 years (stepchild, foster/adopted child, child of cohabiting partner also included).

D. This child has lived together in the same household with affected parent for at least 6 months of the past 12 months.

E. Young person is able to participate in the interview i.e. no lack of language ability or disorders of speech and language, which do not allow a participation in the interview, no learning disorder or 'mental retardation', child has not been in in-patient psychiatric treatment during the past 12 months.

4.2.3 Interviews

It was decided to seek to interview children and young people aged between 12 and 18 years old. An in-depth semi-structured interview was held with children and young people for whom consent had been granted by the parent, or person with parenting responsibility, authorised to do so. These interviews were carried out by trained interviewers - clinical psychologists, educationalists, or experienced child researchers. The interview schedule (Alcohol Violence – Teenager version [ALVI-T]) was developed specifically for this project, to be implemented in different languages and different countries. Versions were developed in German, English, Spanish, Polish, Hungarian and Finnish (and whenever a standardised version of any of the scales used [see below] was available in a participating country's language, this was the one used). The German and the English versions, alongside an internal project document outlining the sources used to create the interview, are available for downloading as PDF documents on the ENCARE website (www.encare.info). In brief, the interview schedule was a mixture of quantitative and qualitative elements, with some self-report questionnaires, some interviewer coded questionnaires, some closed questions to be posed by the interviewers with specified answer categories, and some more open interview questions, some for ad hoc or post hoc coding, others to form the basis of a more qualitative report which each country was asked to provide. The final interview schedule consists of the following sections:

- a 'time line', to establish a framework of the past 12 months during which the young person has lived together with the parent(s) and to develop a positive atmosphere in which a confidential conversation can take place;
- socio-demographic and family information
- parental health, looking at relevant parental physical and mental health problems and treatment
- the CAST (Children of Alcoholics Screening Test, modified version) (Pilat and Jones, 1985; Clair and Genest, 1992), plus other 'filter' questions about the levels of parental drinking and associated problems

- further questions about the parents' alcohol problems (if parents met basic problem-alcohol-use criteria and were drinking problematically during the past 12 months)
- who the young person finds supportive
- the Achenbach Youth Self-Report scale (YSR 11-18) (Achenbach & Rescorla, 2001), where the 101 problem items fall into 8 scales: Withdrawn/depressed, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour; and 3 groups: internalizing, externalizing, mixed behaviour.
- The young person's rating of their own health and substance use
- Injuries and accidents during past 12 months. Injuries were defined as: "All injuries are included whatever their cause: i.e. this includes unintentional injuries and injuries inflicted by third persons. Not included are: complications following medical or surgical procedures, adverse side-effects from medication or long-term effects of injuries" and were coded using WHO classifications, according to the International Classification of External Causes of Injuries (ICECI, 2004; http://www.rivm.nl/who-fic/ICECIeng.htm (31/07/2007)); in this project, the following ICECI categories for coding were used: Intent, Mechanism of Injury, Place of occurrence, alcohol use, psychoactive drug or substance use. Questions and categories also adapted from a number of other studies and questionnaires.
- Family Conflicts, especially utilising the Conflict Tactics Scales (Straus, Hamby & Warren, 2003) using child versions of both the scale examining conflicts between parents (CTS2-CA), and the scale examining parent-child conflicts (CTSPC-CA). Additionally, a narrative description of a typical situation when a (physical) argument in the family occurs was obtained, as well as other conflict-related information (such as the involvement of third persons, intoxication of parents, emotions, frequency, consequences, etc)
- Coping, especially using KIDCOPE (Spirito, Stark & Williams, 1988), a clinical checklist to assess coping of children and young persons. It provides scales examining various forms of coping: distraction, social withdrawal, cognitive restructuring, self criticism, blaming others, problem solving, emotional regulation, wishful thinking, social support and resignation. KIDCOPE was used twice in each interview: once about coping with 'alcohol problems in the family', and once with respect to coping with 'physical fights in the family'. Again, some further questions were also asked more generally about coping with alcohol problems/violence by talking to family members/relatives, friends/acquaintances, professionals, and experiences of talking to others. Additionally, questions were asked about the young person's support needs, knowledge of available services, previous help received, actual help needs, and wishes for the future about self, mother and father.
- Finally, feedback was obtained about the interview.

The original aim was to develop and implement a standardised interview to guide the 10 countries in gathering direct information from young people (as mentioned in 2.1, there were other elements to this project such as examining different countries policy positions on co-existing alcohol problems and domestic abuse within the family). However, the development of the interview schedule was a long process due to national differences in research approaches, ethical and legal regulations, different languages, etc., and in the event, partners in only 5 of the 10 countries managed to interview any young people. This result will be discussed in more detail later in this report. The interview schedule was tested before being finalised and

agreed: pre-tests were undertaken by psychologists/therapists in Germany, 3 pilot interviews were undertaken in Germany, and one pilot interview was done in Hungary.

The interview was a long one: the mean interview time was 1 hour 45 minutes, with a range of between 1:05 and 2:45. In contrast, the interviews with the comparison cases had a mean time of 1:05, range 0:45-1:30. The length was needed in order to be able to develop a trusting relationship so that information could be revealed, and to allow for both standardised data to be collected as well as to allow for more open qualitative data. One technique to allow the young person to feel more at ease and hence to reveal more was to include components in the interview which the young person would be likely to find less stressful; but this also increased the length. The large majority of the children and young people who were interviewed said that they had found it helpful to have the opportunity to talk at some length about their experiences, an opportunity that many of them had not had previously. This underlines the lack of professional attention that these children and young people had received (and these were young people whose parents were already in treatment!) and reinforces the need to develop more responsive services for this hidden population.

4.2.4 Ethical and other approvals

Each of the participating project partners in each country needed to obtain various approvals before this project could be undertaken in that country. One important finding from this study was that the various European states have quite different ways of dealing with research on the topic of child welfare. Whilst in some countries, a previous history of threats to a child's well-being which now no longer acutely exists need not be reported to the state welfare services for young people, the rules in other countries state that any type of threat to a child's well-being, even if in the past, must be notified to the authorities by the researcher involved. In this respect it makes empirical studies very difficult as, despite the anonymity and confidentiality that is ensured by the research project, in those countries where this ruling obtains, parents must fear being reported to the authorities even if acts of violence no longer occur.

It was also the case that the ethical procedures in some countries led either to very long delays (which in some cases meant that that country could not participate), or to a refusal to allow the research to go ahead. This issue is looked at in more detail in the Discussion (Chapter 7).

4.3 Participating countries and children

4.3.1 Numbers

57 children and young people with parents with serious alcohol problems, between the ages of 12 and 18 years, were recruited into this project and interviewed, from Germany (27), England (8), Malta (3), Poland (13) and Spain (6). A further 13 children and young people were recruited in Germany as comparison cases. The data from these 57 children and young people were examined very closely, and 12 of them were subsequently excluded from the quantitative analyses (6 from Germany, 3 from England, 3 from Poland), due to concerns that the alcohol problem might not have been current within the previous 12 months and/or that the child might not have been living with the parent (and hence had not been exposed directly to the alcohol problem) for sufficient time over the previous year. In essence, it was decided to be particularly

conservative, so as to ensure that we could be absolutely certain that the data we used came from children who did have a parent with a serious alcohol problem and who were significantly exposed to that problem. The final data set reported on below (Table 1) consists of 45 children and young people with parents with serious alcohol problems. In a small number of cases, more than one sibling from the same family was interviewed.

Table 1: Numbers of young people interviewed in each country

Country	Number	Percent
Germany	21	46.7
Poland	10	22.2
Spain	6	13.3
England	5	11.1
Malta	3	6.7
Total	**45**	**100.0**

4.3.2 Age and Gender

Table 2 shows the age and gender breakdown of the young people.

Table 2: Age and gender of young people

Age	Number	Percent	Gender	Number	Percent
12	6	13.3	Male	16	35.6
13	4	8.9	Female	29	64.4
14	10	22.2			
15	8	17.8			
16	6	13.3			
17	8	17.8			
18	3	6.7			
Total	**45**	**100.0**	**Total**	**45**	**100.0**
Mean age	**14.89**				
SD	**1.81**				
Median age	**15.00**				

4.3.3 Parental alcohol and mental health problems

Table 3 shows the numbers of young people with mothers[1], fathers[2] or both parents with alcohol problems according to the inclusion criteria. It should be noted that the high percentage of mothers with alcohol problems in the samples from England, Spain and Germany is not representative of prevalence rates in those countries, nor of rates of males and females within treatment services in those countries, nor across the EU as a whole.

Table 3: Numbers of young people with mothers, fathers or both parents with alcohol problems according to the inclusion criteria

Country	Number of fathers with alcohol problems	% of young people in that country with fathers with alcohol problems	Number of mothers with alcohol problems	% of young people in that country with mothers with alcohol problems	Number of both mothers and fathers with alcohol problems
Germany	14	66.7	10	47.6	3
Poland	10	100.0	0	00.0	0
Spain	3	50.0	3	50.0	0
England	1	20.0	4	80.0	0
Malta	2	66.7	1	33.3	0
Total	**30**		**18**		**3**

15 out of the 45 young people also had a mother, and 4 had a father, with a mental health problem in the previous year (as reported by the young person). 13 out of the 15 mothers, and all four of the fathers, received help for this mental health problems (such as seeing a doctor, talking to a psychologist or psychotherapist, going to hospital, taking medication, etc), as far as the young person knew.

4.3.4 Children and young people's assessment of the interview experience

The children and young people's assessments of their interview experience were generally very positive. They were asked, at the end of the interview, to rate their experience on a 1-10 scale (1= very negative, 10 = very positive): the mean rating of the 45 interviews was 7.96 (SD 2.18, median = 9). Girls tended to rate the interviews more positively than did boys (girls mean = 8.38, SD 1.9; boys mean = 7.19, SD 2.5).

One quote sums up what many of the young people thought about the interview:
"No-one has ever asked me before about how I feel about any of this! Thank you!".

[1] 'Mother' also includes any maternal parenting figure.
[2] 'Father' also includes any paternal parenting figure.

5 Results of the ALC-VIOL study

The Stress-Strain-Coping-Support model (Velleman & Templeton, 2003) is a useful one to use in examining the data collected and reported below. This model suggests that living in environments where a parent or other close relative misuses alcohol or drugs is very **stress**ful; this stress causes **strain** on the young person (often showing itself through physical or psychological symptoms); and the degree of stress is mediated by the **coping** mechanisms utilised, and the level and quality of **social support** available.

The main focus for this report is on the children whose parents had serious alcohol problems. The comparison cases are only used in those area (such as parental violence and aggression) where it is useful to look at these comparison cases to gain a further perspective.

5.1 Stressful experiences

For those 30 children and young people whose father had an alcohol problem[3], the young people reported that their father's drinking had been a problem for them since their mean age was 7.96 (SD 4.24). 18 of the 30 children stated that their father's alcohol drinking had been a problem for them from the age of 10 or younger (two from birth; one each from the ages of 1, 2, 3, 4, 5, 7 and 10; four each from the ages of 6 and 8; two from the age of 9). They reported that they had been exposed to their father's alcohol problem for between 1 and 14 years (mean reported exposure was 6.63 years, [SD 4.46]).

For those 18 children and young people whose mother had an alcohol problem, the young people reported that their mother's drinking had been a problem for them since their mean age was 10.18 (SD 3.88). 8 of the 18 children stated that their mother's alcohol drinking had been a problem for them from the age of 10 or younger (one each from the ages of 3, 4, 5, 7, 8 and 10; two from the age of 9). Similarly to the case with father's drinking, they reported that they had been exposed to their mother's alcohol problem for between 1 and 14 years (although the mean reported exposure was slightly less: 5.35 years, (SD 3.77).

The children and young people were asked a number of questions about their experiences during the past 12 months. 39 of the 45 children and young people stated (on a 5-point scale from 'never' to '(almost) always') that either or both of their mother or their father drank heavily at home - Fathers: 1 x sometimes; 9 x often; 11 x (almost) always; Mothers: 1 x sometimes; 5 x often; 12 x (almost) always.

23 of the 45 children and young people stated (using the same 5-point scale) that either or both of their mother or their father came home already drunk - Fathers: 3 x sometimes; 8 x often; 6 x (almost) always; Mothers: 1 x sometimes; 2 x often; 3 x (almost) always.

[3] As described above, all children and young people had at least one parent (or parental figure, such as a step-parent etc) with a significant known alcohol problem. For recruitment purposes, we started with the information from the co-operating institution about the parental alcohol problem, but this was also checked in the interview, and operationalised as a score of 5+ on the Children of Alcoholics Screening Test (CAST) and that they were actively drinking at a problematic level during the past 12 months.

35 of the 45 children and young people stated (again using the same 5-point scale) that either or both of their mother or their father got very drunk (e.g. had slurred speech, had problems walking or collapsed) - Fathers: 4 x sometimes; 7 x often; 9 x (almost) always; Mothers: 5 x sometimes; 5 x often; 5 x (almost) always.

As outlined in section 4.2.3 above, a modified version of the CAST (Children of Alcoholics Screening Test) was used in this study. 30 of the fathers of these children and young people scored above the cut-off of 5[4] on this scale. Of these 30, their average score on the 29 items of the CAST was 16.80 (SD 5.21, range 7-27). 19[5] of the mothers of these children and young people scored above the cut-off of 5 on this scale. Of these 19, their average score on the 29 items of the CAST was 20.42 (SD 6.40, range 12-29).

As well as providing a useful corroboration of the fact that the parents in this study did have alcohol problems of a severity to make them comparable with previous research in this area, the questions also allow a greater degree of insight into the actual experiences of these young people, as shown in Table 4.

Table 4: The 29 items of the modified CAST used in ALVI-T (only for fathers [n=30] and mothers [n=19] with CAST score 5+)

CAST item	Number (and %) saying 'yes' for the item for 'Father'	Number (and %) saying 'yes' for the item for 'Mother'
Have you ever wished that *a parent* would stop drinking?	28 (93%)	19 (100%)
Have you ever thought that *one of your parents* had a drinking problem?	26 (87%)	17 (90%)
Have you ever heard *your parents* fight when one of them was drunk?	26 (87%)	16 (84%)
Have you ever felt alone, scared, nervous, angry or frustrated because *a parent* was not able to stop drinking?	26 (87%)	15 (79%)
Have you ever thought *a parent* was an alcoholic?	26 (87%)	15 (79%)
Have you ever wished your home could be more like the homes of your friends who did not have a *parent* with a drinking problem?	25 (83%)	18 (95%)
Have you ever worried about *a parent's* health because of his or her alcohol use?	24 (80%)	18 (95%)
Have you ever resented *a parent's* drinking?	24 (80%)	17 (90%)
Have you ever felt like hiding or emptying *a parent's* bottle of alcohol?	22 (73%)	17 (90%)
Do many of your thoughts revolve around a problem-drinking *parent* or difficulties that arise because of his or her drinking?	21 (70%)	17 (90%)
Have you ever encouraged *one of your parents* to quit drinking?	20 (67%)	18 (95%)
Has *a parent* ever yelled at or hit you or other family members when drinking?	20 (67%)	13 (68%)

[4] The cut-off in the original 30-item scale was 6. We used a modified 29-item scale, with a cut-off of 5. Our modified version also rated each parent separately.

[5] Although 19 scored above the cut-off, one of them did not meet the other criterion of actively drinking during the past 12 months.

CAST item	Number (and %) saying 'yes' for the item for 'Father'	Number (and %) saying 'yes' for the item for 'Mother'
Have you ever feared that *your parents* would get divorced or split up due to *your father's* or *your mother's* alcohol misuse? (Or, if parents are divorced or separated, do you think this separation was due to your parent's alcohol problems).	20 (67%)	13 (68%)
Have you ever wished that you could talk to someone who could understand and help the alcohol-related problems in your family?	19 (63%)	15 (79%)
Have you ever argued or fought with *a parent* when he or she was drinking?	18 (60%)	18 (95%)
Have you ever lost sleep because of *a parent's* drinking?	17 (57%)	12 (63%)
Has *a parent* ever made promises to you that he or she did not keep because of drinking?	16 (53%)	12 (63%)
Did you ever feel caught in the middle of an argument or fight between your problem drinking *father* or your problem drinking *mother* and your other *parent*?	16 (53%)	10 (53%)
Have you ever protected another family member from *a parent* who was drinking?	15 (50%)	12 (63%)
Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about *a parent's* drinking?	14 (47%)	16 (84%)
Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over *a parent's* drinking problem?	14 (47%)	10 (53%)
Have you ever stayed away from home to avoid the drinking *parent* or your other parent's reaction to the drinking?	13 (43%)	11 (58%)
Have you ever felt that a problem-drinking *parent* did not really love you?	13 (43%)	9 (47%)
Have you ever threatened to run away from home because of *a parent's* drinking?	9 (30%)	11 (58%)
Have you ever felt responsible for and guilty about *a parent's* drinking?	8 (27%)	12 (63%)
Have you ever taken over any chores and duties at home that were usually done by *a parent* before he or she developed a drinking problem?	8 (27%)	19 (53%)
Have you ever been blamed for *a parent's* drinking?	6 (20%)	9 (47%)
Have you ever felt that you made *a parent* drink alcohol?	5 (17%)	7 (37%)
Have you ever fought with your brothers and sisters about *a parent's* drinking?	5 (17%)	1 (5%)
Mean of items ticked	**16.80**	**20.42**
	Father	**Mother**

It can be easily seen that the young people we interviewed lived through a great number of negative experiences, and also that they suffered a greater number of negative experiences if they had a mother with a drinking problem as opposed to having a father with one. Further, for all except four of these items in Table 4, a greater percentage of these young people ticked each experience if their mother had the problem than if their father did.

5.2 Stressful experiences specifically in relation to aggression and violence

Clearly, a number of the items listed in Table 4 relate to aggression and violence: 'Have you ever argued or fought with *a parent* when he or she was drinking?', 'Has *a parent* ever yelled at or hit you or other family members when drinking?', 'Have you ever fought with your brothers and sisters about *a parent's* drinking? ', 'Have you ever heard *your parents* fight when one of them was drunk?', 'Have you ever protected another family member from *a parent* who was drinking?' and 'Did you ever feel caught in the middle of an argument or fight between your problem drinking *father* or your problem drinking *mother* and your other *parent*?'. As can be seen from Table 4, with virtually all of these items, a high number and percentage of young people ticked them.

In addition, 17 out of 45 (39.5%) of the children said that they had been afraid of their father because of his drinking, and 6 out of 45 (14%) said that they had been afraid of their mother because of her drinking, at some time in their lives. In fact, the only young people who said they were afraid of their parent when drinking were those where the parent had an alcohol problem: this means that in fact 17 out of the 30 young people (57%) with a father with an alcohol problem said that they had been afraid of their father because of his drinking, and 6 out of the 19 young people (32%) with a mother with an alcohol problem said that they had been afraid of their mother because of her drinking.

As outlined in section 4.2.3, we also used the Conflict Tactics Scales (CTS2-CA and CTSPC-CA) to examine aggression and violence both between parents, and between each parent and the responding young person, within the previous year. The Conflict Tactics Scales divide aggression and violence into various categories (for each category, one or more examples of each is given): *psychological aggression* (insulted or swore at; destroyed the recipient's possession; threatened to hit or throw something at), *minor physical assault* (slapped; twisted arm or hair), *severe physical assault* (used a knife, gun or weapon; punched or hit with a hard object; choked; burned or scalded; beat up), *minor injury* (sprain, bruise or small cut due to the fight; feeling physical pain the next day due to the fight), *severe injury* (broken bone; needing to go to the doctor; becoming unconscious after being hit on the head in a fight). These categories are used both in relationship to parent-to-parent violence and parent-to-child violence, except that with parent-to-child violence, the 'injuries' category is not used; instead there is a category of *extreme physical assault* from a parent (grabbing around the neck and choking, beating up, hitting over and over as hard as possible, threatening with a weapon, burning or scalding on purpose).

Tables 5[6] and 6 show the number and percentage of cases where young people experienced aggression or violence between or by their parents. Table 5 shows the experiences between parents, without them being separated by whether or not each parent had an alcohol problem, and in comparison to the results from the comparison group (the number of cases are smaller than the total sample in both cases because only children who had been living together with two parents could complete this questionnaire). Table 6 sub-divides these results by whether the father or mother perpetrating the aggression or violence had an alcohol

[6] Because these CTS Tables can be confusing to read, we have an example at the bottom of each Table.

problem. Tables 7 and 8 repeat these analyses, but for the relationship between each parent and the child or young person.

It can be seen from Table 5 (below) that very high percentages of the sample with parental alcohol problems reported violence between their parents causing injuries, or severe physical assaults between their parents, or severe psychological aggression between their parents. The level of violence reported between parents was sometimes extreme. Children and young people reported violence between their parents causing serious injury to those parents, including parents passing out and becoming unconscious due to being hit on the head in a fight with the other parent, parents needing to go to the doctor because of a fight with the other parent, and parents having a broken bone from a fight with the other parent. These children and young people also reported other severe physical assaults between their parents, including that their parent used a knife or weapon on the other parent, that they punched or hit the other parent with something that could hurt him or her, that one parent choked the other parent or slammed them against a wall or burned or scalded the other parent on purpose. In many other cases the children and young people also reported significant amounts of more minor physical assaults, and of psychological aggression between their parents. It is clear that violence and aggression was not a rarity in these families.

It can be seen from Table 5, in relation to the comparison group and for all categories, that the parental relationships in which one parent had an alcohol problem showed considerably higher levels of all forms of aggression and violence. In the comparison sample (although the numbers are very small) there are few differences between aggression from fathers to mothers versus mothers to fathers. Within the parental problem drinking sample, however, it looks more as if there is more violence and aggression from fathers to mothers than vice versa. It is worth emphasising that this is not caused by there being more fathers with alcohol problems in the sample than mothers with alcohol problems.

Indeed, from Table 6, which examines these results in more detail, it can be seen that the picture is more complex, showing generally an interaction between gender and alcohol problems. Males without alcohol problem but in relationships with women with alcohol problems do seem much more likely to be aggressive or violent towards their spouses than do females without alcohol problem who are in relationships with men with alcohol problems; but males with alcohol problems do not seem to be more likely to be aggressive or violent towards their spouses than do women with alcohol problems. It is likely that there is a gender specific relationship with respect to violence, as well as an alcohol-related one (Galvani, 2004, 2007a).

Table 5: The CTS2-CA: Aggression and violence between my parents during the past 12 months (main sample versus comparison sample)

The young person experienced <u>at least one form of</u> … during the past 12 months:		**Sample with parental alcohol problems (n=41)**		**Comparison Sample (n=9)**	
Scale		Father against mother: number (and %)	Mother against father: number (and %)	Father against mother: number (and %)	Mother against father: number (and %)
Psychological Aggression	Minor	37 (90%)	34 (83%)	5 (56%)	5 (56%)
	Severe	20 (49%)	13 (32%)	2 (22%)	1 (11%)
Physical Assault	Minor	22 (54%)	14 (34%)	1 (11%)	1 (11%)
	Severe	15 (37%)	9 (22%)	0 (0%)	1 (11%)
Injuries		13 (32%)	8 (20%)	0 (0%)	0 (0%)
<u>Example</u>: 54% of ChAPAPs report having experienced at least one form of Minor Physical Assault by their father against their mother, during the past 12 months. This is a total of 22 ChAPAPs out of the 41 for whom we have data on this scale.					

Table 6: The CTS2-CA: Aggression and violence between my parents during the past 12 months (comparing fathers and mothers with and without alcohol problems)

The young person experienced <u>at least one form of</u> … during the past 12 months:		**Sample with parental alcohol problems (n=41)**			
Scale		Father against mother		Mother against father	
		Father <u>with</u> alcohol problem: number (and %) (n=28)	Father <u>without</u> alcohol problem: number (and %) (n=13)	Mother <u>with</u> alcohol problem: number (and %) (n=16)	Mother <u>without</u> alcohol problem: number (and %) (n=25)
Psychological Aggression	Minor	26 (93%)	11 (85%)	15 (94%)	19 (76%)
	Severe	16 (57%)	4 (31%)	7 (44%)	6 (24%)
Physical Assault	Minor	14 (50%)	8 (62%)	9 (56%)	5 (20%)
	Severe	11 (40%)	4 (31%)	5 (31%)	4 (16%)
Injuries		7 (25%)	6 (46%)	6 (38%)	2 (8%)
<u>Example</u>: 56% of ChAPAPs whose <u>mother</u> has an alcohol problem report having experienced at least one form of Minor Physical Assault by their mother against their father, during the past 12 months. This is a total of 9 ChAPAPs out of the 16 who have mothers with alcohol problems.					

In terms of the violent and aggressive incidents most frequently reported by children about their parents on the CTS2-CA, the 10 most frequent incidents between fathers and mothers (with fathers as perpetrators) were as follows (the ranking is based on the sum of the frequency of each incident over n=41 cases; the percentage is based on how many children experienced it at least once in the past 12 months):

- Father insulted or swore at mother. (Rank 1; 78%)
- Father shouted or yelled at mother. (Rank 2; 78%)

- Father stomped out of the room or house during a disagreement with mother. (Rank 3; 63%)
- Father pushed or shoved mother. (Rank 4; 46%) same rank as:
- Father did something to spite mother. (Rank 4; 40%)
- Father grabbed mother. (Rank 5; 44%)
- Father threatened to hit or throw something at mother. (Rank 6; 32%)
- Father twisted mother's arm or hair. (Rank 7; 24%) same rank as:
- Father called mother fat or ugly. (Rank 7; 27%)
- Mother had a sprain, bruise or small cut because of a fight with father. (Rank 8; 29%)

The 10 most frequent incidents between fathers and mothers (with mothers as perpetrators) were as follows: (again the ranking is based on the sum of the frequency of each incident over n=41 cases; the percentage is based on how many children experienced it at least once in the past 12 months):

- Mother shouted or yelled at father. (Rank 1; 71%)
- Mother insulted or swore at father. (Rank 2; 65%)
- Mother stomped out of the room or house during a disagreement with father. (Rank 3; 56%)
- Mother did something to spite father. (Rank 4; 35%)
- Mother pushed or shoved father. (Rank 5; 28%)
- Mother threatened to hit or throw something at father. (Rank 6; 22%)
- Mother threw something at father that could hurt. (Rank 7; 25%)
- Mother twisted father's arm or hair. (Rank 8; 13%) same rank as:
- Father had a sprain, bruise or small cut because of a fight with mother. (Rank 8; 17%) same rank as:
- Mother grabbed father. (Rank 8; 17%)

With Tables 7 and 8 (below), it can be seen that the levels of violence and serious aggression from parents to children was much less than between the parents, although levels of psychological aggression (such as being insulted or swore at, being threatened) were still very high. However, although the levels of violence were lower, when it occurred it was still quite major. Some children reported extreme physical assault from their parents, with one case reporting that his/her 'Father grabbed me around the neck and choked me' on one occasion in the last year, and also that his/her 'Father beat me up by hitting me over and over as hard as he could' on two occasions in the last year. Another case reported that his/her 'Father threatened me with a weapon, e.g. knife, bottle, chair' on 3-5 occasions over the past year. Yet another case reported that his/her 'Father burned or scalded me on purpose'. Other instances were reported of 'Father (or Mother) hit me with a fist or kicked me hard' or that 'Father (or Mother) hit me on some other part of the body besides the bottom with something like a belt, hairbrush, a stick or some hard object' or that 'Father (or Mother) threw or knocked me down'. Many children reported minor physical assault from their parents, including 'Mother (or Father) shook me', 'Mother (or Father) slapped me on the face or head or ears', 'Mother (or Father) pinched me' or 'Mother (or Father) slapped me on the face or head or ears'. There was also considerable psychological aggression from their parents, including that their 'Father (or mother) shouted, yelled or screamed at me', 'Father (or mother) cursed or swore at me', 'Father (or mother) said he would send me

away or kick me out of the house', 'Father (or mother) threatened to spank or hit me but did not actually do it' and 'Father (or mother) called me stupid or lazy or some other name like that'.

Again it can be seen from Table 7 that, in relation to the comparison group and for all categories, the parents who had an alcohol problem showed considerably higher levels of all forms of aggression and violence against the child too. As with parent to parent violence, so with parent to child violence and aggression - in the comparison sample (although again the numbers are very small) there are few differences between aggression from fathers to children versus mothers to children. Within the parental problem drinking sample, however, it looks more as if there is more violence (although not more psychological aggression) from fathers to children as opposed to from mothers to children.

Table 7: The CTSPC-CA: Aggression and violence between my parents and me during the past 12 months (main sample versus comparison sample)

The young person experienced <u>at least one form of</u> … during the past 12 months:		**Sample with parental alcohol problems**		**Comparison Sample**	
Scale		Father against child: number (and %) (n=42)	Mother against child: number (and %) (n=43)	Father against child: number (and %) (n=9)	Mother against child: number (and %) (n=12)
Psychological Aggression		31 (74%)	31 (72%)	5 (56%)	7 (58%)
Physical Assault	Minor	20 (48%)	15 (35%)	3 (33%)	3 (25%)
	Severe	9 (21%)	6 (14%)	0 (0%)	0 (0%)
	Extreme	5 (12%)	4 (9%)	0 (0%)	0 (0%)
<u>Example</u>: 21% of ChAPAPs report having experienced at least one form of Severe Physical Assault by their father against themselves, during the previous 12 months. This is a total of 9 ChAPAPs out of the 42 for whom we have data relating to their fathers on this scale.					

Table 8: The CTSPC-CA: Aggression and Violence between my parents and me during the past 12 months (comparing fathers and mothers with and without alcohol problems)

The young person experienced <u>at least one form of</u> … during the past 12 months:		**Sample with parental alcohol problems**			
Scale		Father against child (n=42)		Mother against child (n=43)	
		Father <u>with</u> alcohol problem (n=29)	Father <u>without</u> alcohol problem (n=13)	Mother <u>with</u> alcohol problem (n=18)	Mother <u>without</u> alcohol problem (n=25)
Psychological Aggression		23 (79%)	8 (62%)	15 (83%)	16 (64%)
Physical Assault	Minor	16 (55%)	4 (31%)	7 (39%)	8 (32%)
	Severe	6 (21%)	3 (23%)	6 (33%)	0 (0%)
	Extreme	4 (14%)	1 (8%)	3 (17%)	1 (4%)
<u>Example</u>: 33% of ChAPAPs whose <u>mother</u> has an alcohol problem report having experienced at least one form of Severe Physical Assault by their mother against themselves, during the previous 12 months. This is a total of 6 ChAPAPs out of the 18 who have mothers with alcohol problems.					

Again these relationships change when more detail is examined in Table 8. Generally fathers without alcohol problem but in relationships with mothers with alcohol problems show similar levels of aggression and minor assault towards their children than do mothers without alcohol problems who are in relationships with fathers with alcohol problems, but these fathers do show more severe and extreme assault towards their children than do mothers (although numbers here are very small). Again, fathers with alcohol problems do not seem to be more likely to be aggressive or violent towards their children than do mothers with alcohol problems.

We again looked at the most frequently reported violent and aggressive incidents from parents to the children as shown by the CTSPC-CA. The 7 most frequent incidents between fathers and children were as follows (the ranking is based on the sum of the frequency of each incident over n=42 cases; the percentage is based on how many children experienced it at least once in the past 12 months):

- Father shouted, yelled or screamed at me. (Rank 1; 71%)
- Father called me dumb or lazy or some other name like that. (Rank 2; 52%)
- Father cursed or swore at me. (Rank 3; 48%)
- Father shook me. (Rank 4; 33%)
- Father threatened to spank me but did not actually do it. (Rank 5; 32%)
- Father slapped me on the hand, arm or leg. (Rank 6; 24%) same rank as:
- Father slapped me on the face, or head, or ears. (Rank 6; 21%)

The 5 most frequent incidents between mothers and children were as follows: (again the ranking is based on the sum of the frequency of each incident over n=43 cases; the percentage is based on how many children experienced it at least once in the past 12 months):

- Mother shouted, yelled or screamed at me. (Rank 1; 61%)
- Mother called me dumb or lazy or some other name like that. (Rank 2; 49%)
- Mother cursed or swore at me. (Rank 3; 35%)
- Mother said she would send me away or kick me out of the house. (Rank 4; 23%)
- Mother slapped me on the hand, arm or leg. (Rank 5; 19%)

Although extreme physical assaults towards children were not common (12% from fathers, 9% from mothers), when they occurred they had significant effects. Hence two children told us that they had been injured during fights with their parents which resulted in them being unable to undertake normal activities, or to be medically treated, and for one of these children this occurred between 3 and 5 times in the previous 12 months alone. Ten children told us that, over the past year, they had been in physical fights with their parent of an intensity that they were still in pain the next day. For three of these ten children this just occurred once in the previous year, but others reported this being much more regular – four of them said this occurred 3-5 times, and two others said it was much more frequent than that. Similarly, three children said that, in the past year, they had to stay in bed for at least half a day due to injuries received in a physical fight with a parent; seven children missed at least a day at school for the same reason (for two children, this happened 3-5 times in the past year alone); and nine children told us that they had to miss at least one day of other

activities such as sports or hobbies due to the effects of a physical fight with a parent. There were also very high percentages of children reporting minor (48% from fathers, 35% from mothers), and severe (respectively 21% and 14%) physical assaults.

It is clear then that very considerable aggression and quite significant violence was reported within these children and young people's parental homes, both between their parents and from one or both parents to the children.

5.3 Strain: effects and 'symptoms'

The results in the two sub-sections above demonstrate that these children and young people have had very many negative experiences related to their parents' drinking: on average the parental drinking had been a problem for a long time, there was considerable drinking in the family home as well as parents coming home already drunk, and when drunk parents showed many negative signs of that drunkenness (slurred speech, difficulty walking, collapsing, etc). They also show that there was considerable aggression and violence, some of it quite serious, within these children's homes as they were growing up.

What effects did this upbringing have on these children?

This was examined in a number of ways. First, the Achenbach Youth Self-Report (YSR 11-18; Achenbach & Rescorla, 2001) was used. This examines 101 problem items and places them into 8 sub-scales (anxious/depressed, social withdrawal, somatic complaints, rule-breaking behaviour, aggressive behaviour, social problems, thought problems [the German version names this sub-scale 'schizophrenic and compulsive symptoms'] and attention problems) and also into two overall scales: internalizing, externalizing; and a total. All of these scales and sub-scales have norms (different for different countries) showing levels of scoring which imply normal behaviour or borderline or clinical levels of problem. Different appropriate norms were used (if they existed) for each of the countries from which we collected data. As shown in Table 9, we found that 6 of these children and young people had Total scores which placed them within the 'Borderline Clinical Range' and a further 10 fell fully within the 'Clinical Range' of problems: in all then, 16 out of 45 children, or 36%, reached 'Borderline Clinical' or 'Clinical' levels. (As will be seen from Table 9 below, in some cases, children reached 'Borderline Clinical' levels on particular individual sub-scales, but when these were added together to form the overall scales, these children then fell within the 'Clinical' range.) Table 9 also shows that roughly similar percentages of boys and girls reached the clinical range for both sub-scales and for the total problems, but that a higher percentage of girls than boys reached borderline clinical levels.

Table 9: Results from the Achenbach Youth Self-Report: problems affecting children and young people living with parental alcohol and domestic abuse (N=45)

Numbers (and %) of children in the 'Borderline Clinical Range', and in the 'Clinical Range', for each sub-scale, for the Internalising and Externalising Scales, and for Total Problems, and by Sex						
Scale or sub-scale	**Borderline Clinical Range**			**Clinical Range**		
	Boys (n=16)	**Girls (n=29)**	**Total (N=45)**	**Boys (n=16)**	**Girls (n=29)**	**Total (N=45)**
INTERNALISING	0	5 (17%)	5 (11%)	4 (25%)	6 (21%)	10 (22%)
Anxious/depressed	2 (13%)	4 (14%)	6 (13%)	0	1 (3%)	1 (2%)
Social withdrawal	2 (13%)	4 (14%)	6 (13%)	1 (6%)	2 (7%)	3 (7%)
Somatic complaints	0	5 (17%)	5 (11%)	3 (19%)	0	3 (7%)
EXTERNALISING	2 (13%)	6 (21%)	8 (18%)	3 (19%)	4 (14%)	7 (16%)
Rule-breaking behaviour	0	3 (10%)	3 (7%)	1 (6%)	2 (7%)	3 (7%)
Aggressive behaviour	0	2 (7%)	2 (4%)	3 (19%)	0	3 (7%)
FURTHER SUB-SCALES[1]						
Social problems	0	1 (3%)	1 (2%)	1 (6%)	2 (7%)	3 (7%)
Thought problems	0	3 (10%)	3 (7%)	1 (6%)	2 (7%)	3 (7%)
Attention problems	2 (13%)	4 (14%)	6 (13%)	1 (6%)	2 (7%)	3 (7%)
TOTAL	**1 (6%)**	**5 (17%)**	**6 (13%)**	**4 (25%)**	**6 (21%)**	**10 (22%)**

[1] Three further sub-scales do not add into either of the two scales (Internalising, Externalising) although they do add into the Total score.

As well as using the Youth Self-Report (YSR 11-18) we also asked a number of further questions. 13 out of the 45 children and young people (29%) reported having had contact with Mental Health services (e.g. been to see a psychologist, a psychotherapist, a psychiatrist or a counsellor, or had to take medication because of a mental-health problem). 7 of them had seen someone in the past; 6 were still currently seeing someone.

It is clear then that around one third of these children and young people had significant problems as measured both by the Youth Self-Report and by their contact with mental health services.

We also asked about their current alcohol and drug use and misuse.

5.3.1 Alcohol

27 out of 45 (60%) had drunk alcohol in the previous 6 months (50% of boys and 66% of girls). This group included one out of the six 12-year olds (17%); but mainly these were children aged 14 and older (0% of 13-year-olds, 60% of 14-year-olds, 75% of 15-year-olds, 83% of 16-year-olds, 75% of 17 year-olds and 100% of 18-year-olds.

Of those 27 young people drinking alcohol, none stated that they drank everyday and only one said that they drank several times a week – all of the others (26 out of the 27) told us that they drank at a frequency of between weekly and monthly. Correspondingly, drunkenness was rare: these young people told us that they

got very drunk (slurred speech, difficulties walking, having to throw up) on average of 1.27 times over the past 6 months (median 0.0, SD 2.26). 14 of the 27 told us that they had never got drunk within the past 6 months, and 6 of the 27 said this had occurred once. A further 6 young people stated that they had got drunk between 2 times and 10 times over the last 6 months. Those 27 young people who had commenced drinking started at an average age of 13.75 years (median 14, SD 2.11) and although one young person told us that they started drinking at the age of 7 and another one at age 10, all of the others started at 13 or older (3 at age 13, 7 at age 14, 4 at age 15, 6 at age 16).

5.3.2 Drugs

4 out of 45 young people (aged 14, 16, and 17) had used cannabis/hashish/marihuana in the past 6 months. All of them used this drug less than once a week, and two used it less that once a month. Two of them started using cannabis at age 13, the other two at age 16. Only one young person had used an illicit drug other than cannabis.

5.4 Coping

We looked at how children coped with these stresses and strains reported above, by using KIDCOPE, a self-report checklist (Spirito et al., 1988; Pretzlik & Sylva, 1999; Rathner & Zangerle, 1996) which requires the child to think about their specific situation and to assess how they have coped. The 15 statements on the checklist generate 10 coping strategies. The statements and strategies are shown in Table 10. The child rates both use, and perceived effectiveness (if used), of each strategy.

Our inclusion criteria meant that all the children and young people we interviewed had the experience of a parent with an alcohol problem, and they all completed KIDCOPE in relation to this. As reported above, almost all the children also had experience of significant aggression within their family home. We determined from their answers to our questions that in 23 of these 45 cases, that aggression reached a threshold for domestic violence, and on those 23 cases we asked the young people to complete KIDCOPE a second time, in relation to coping with domestic violence within the home.

Almost all of these items and strategies were well used by these children and young people. Table 10 also ranks the 10 strategies (in relation to parental alcohol problems) and shows the ranking of the ratings of effectiveness for those strategies which each child used.

It is interesting (and very positive) that the majority of the most frequently used strategies were also the ones rated as most effective (Social Support, Problem solving, Emotional regulation and Distraction); and conversely the most infrequently rated were generally seen as the least effective (Self-criticism, Resignation and Blaming others). Wishful thinking was the only strategy which was high frequency but seen as relatively ineffective.

Table 10: The 15 Statements and resulting 10 Coping Strategies used in KIDCOPE, with Rankings of 'Frequency of use' and 'Rated Effectiveness if the strategy was used' of the strategies used by these children and young people in relation to their parent's alcohol problem

Statements	Coping Strategies	Frequency of use	Effectiveness if used
try to feel better by spending time with others such as family, grown-ups or friends	Social support	Rank 1	Rank 1
wish the problem had never happened	Wishful thinking	Rank 2	Rank 6
wish you could make things different			
try to sort the problem out by thinking of answers	Problem solving	Rank 3	Rank 2
try to sort it out by doing something or talking to someone about it			
shout, scream, get angry	Emotional regulation	Rank 4	Rank 4
try to calm yourself down			
try to forget it	Distraction	Rank 5	Rank 3
do something like watch telly or play a game to forget it			
stay on your own	Social withdrawal	Rank 6	Rank 7
keep quiet about the problem			
try to see the good side of things	Cognitive restructuring	Rank 7	Rank 5
blame someone else for causing the problem	Blaming others	Rank 8	Rank 8
do nothing because the problem could not be solved	Resignation	Rank 9	Rank 10
blame yourself for causing the problem	Self-criticism	Rank 10	Rank 9

When KIDCOPE was used a second time to examine coping with family violence, the results were extremely similar, although this time wishful thinking (both items) was the most frequently used tactic, with social support being the third most frequently used strategy. Although blaming others was not used very frequently, it was used more as a strategy for dealing with family aggression than for family alcohol problems, and cognitive restructuring (trying to see the good side of things) was the most rarely used strategy when coping with violence.

In summary then, a number of strategies were used by these children and young people to cope with their experience of alcohol problems and related aggression and violence within the family. One of the most common strategies used to cope with both sets of experiences was social support ("I try to feel better by spending time with others such as family, grown-ups or friends") and this was seen by the young people as being one of the most effective strategies too. Another very common strategy was wishful thinking ("I wish

the problem had never happened" or "I wish I could make things different") but the young people also reported that this coping strategy was not very successful. Other, more successful, coping strategies which were also quite frequently used were problem solving (especially "I try to sort it out by doing something or talking to someone about it"), distraction (especially "I do something like watch telly or play a game to forget it "), trying to control their feelings ("I try to calm myself down ") and trying "to see the good side of things ".

As well as using the KIDCOPE questionnaire, we also talked generally to these children and young people about how they coped. What is clear from these comments is that these children and young people rarely use just one strategy to cope – they frequently old us about a number of different strategies which they used. Some of the things that they told us were:

- *"Usually I just go to my room and stay there alone, even after the fighting stops. I play with my cat until dinner time. By then pa would be asleep and it is ok to watch TV with mummy. Sometimes I cry myself to sleep and mummy comes to wake me up. This happens lots - about every two weeks in winter, but less in summer when father stays away from home due to work."*
- *"I just get on with life, I never feel totally great and I carry my problems around with me, but I am just used to it …. I have learned how to cope with it and I have changed, to be able to live with it."*
- *"I escape to my room, I try to play on my computer or do my homework (although my concentration is terrible), I am sad, I am worried about my mother and always expecting 'something worse', I am unable to fall asleep – and the next day I find it difficult to wake up and go to school."*
- *"I am sad, I sit in my room, doing nothing, I have difficulty falling asleep, and when I do my sleep is very disturbed, with nightmares. Sometimes I hear voices telling me to 'escape'. I feel very nervous a lot of the time and I feel very angry and aggressive at school."*
- *"I feel shamed and humiliated because of my father, and I worry about my brother – he gets very aggressive when he gets involved with our parents' arguments."*
- *"Nowadays, I leave the house; but when I was younger I played and pretended not to notice that anything was going on."*
- *"As much as possible, I stay out of the way. When she screams at me, sometimes I scream back and call her names like she calls me, but this is not very often ... just sometimes."*
- *"I cry, I threaten my father, I try to protect my mother… and then I go out, because of the uselessness of any of these efforts!"*
- *"I get angry, I scream, I go to my room and am sad, sometimes I withdraw into myself to avoid arguments. If I realise that an argument is about to start I try to get in between them to stop it; but if everyone starts insulting me, I go to my room and try to distract myself by listening to music."*
- *"Sometime I intervene, shouting, protecting my mother, crying; more often I go to another room, although in that case I am always alert and listening."*
- *"I destroy something: I throw something against a wall or a house or a tree. This makes me feel free and relieved. Sometimes I walk around outside: then I can think and try to cope with what I experienced. Sometimes I cry at my girlfriend's."*
- *"I feel ashamed to talk to people - friends, the police, anyone."*

- *"My friends know the basics but I don't want to involve them too much - it makes them uncomfortable and I don't want them to feel worse. ... Anyway, I am a very private person."*
- *"I find it helpful to talk to Dad and to my sister, because they've had the same experiences and he (my Dad) just wants to support me. My male friend is also just very easy to talk to. My female friends on the other hand feel uncomfortable; they want to help but they can't."*
- *"If I am pissed off, my friend attempts to calm me down and checks if I am alright. We like the same things like playing 'x-box' – he helps me to feel better, especially when I am angry."*
- *"I speak to my aunt, who listens and calms me down."*
- *"My friend cheers me up. And I know someone who has been through a similar experience, and that's helpful. And my teacher is trained to help – he listens and gives advice, which is great."*
- *"I did approach my teacher, but he doesn't know what to say. The same with my boyfriend – he says he understands but he doesn't really know how I feel – he has had no similar experience."*
- *"My boyfriend 'looks after me', supports me in terms of college etc., thinks of me first and calms me down when I fight with my father."*
- *"I make a punch-bag out of a pillow and I use this to get rid of my anger and frustration."*
- *"I did get help from my school counsellor, who made good suggestions as to how I could cope, such as talking to mum or to my siblings or getting my boyfriend involved. I feel that my counsellor understands me."*
- *"Just telling me to leave home isn't helpful: I want them to understand – and not just to say it's all going to be ok. I know that could never be true – even if my mum stops drinking, I'll always be worried. It is more helpful if my friends don't try to sort it out for me."*
- *"The more you talk about it the easier it gets – it's good to get it all out in the open."*
- *"In a way, I wanted my Mum to go back to prison, because she was clean for a few weeks when she came out of prison."*

In general, the most frequent ways of coping that these young people told us were that they: leave the room where fighting takes place (or sometimes they leave the house/apartment), they go to their room to listen to music, they visit friends, they lock themselves in their room, they cry with anger, or they take their anger and frustration out by hitting or breaking something.

Many young people told us that they coped by talking to others, but that these other people needed to be carefully selected. For many it was a relative or a friend, and some mentioned how helpful it was to talk with someone who had been through a similar experience. These methods of coping link in with whether the young people had others who provided them with social support, as discussed below.

5.5 Support

5.5.1 Support generally

The children and young people were asked generally about whether they had someone they could go to who would provide support or comfort if they had problems (such as at school or in their family). All except for one

boy said that they did have at least one person who they could go to, and 22 of them said that they had 3 or more people who they could go to (mean number of 'supporters' = 2.84). These people included parents or step-parents, siblings, grandparents, other relatives (uncles and aunts) and friends.

For those who had more than one close person, they were asked to select the most supportive person. Although the whole range of types of person were chosen as the most supportive by at least one person, the largest groups were mothers (n=17) and friends (n=8). There were strong sex differences here: 56% of boys selected their mother as their main person, compared with 28% of girls selecting their mother. These young people generally saw their most supportive person every day (69%) or several times a week (11%), or at least once a week (9%).

The young people were also given a list of things which some people find comforting (a special item or object such as a talisman, lucky charm, cuddly toy, or other toy; a pet; a diary; some fantasy or dream; and God/religion/praying), and asked if any of these gave them comfort and support them when they had a problem or were feeling sad. 26 (58%) said that a pet was very or quite important, 19 (42%) said that a fantasy was very or quite important, 16 (36%) said that God/religion was very or quite important, 13 (29%) said that a special object was very or quite important, and 4 (9%) said that a diary was very or quite important.

5.5.2 Support about the alcohol and domestic abuse problems

Almost all of the children and young people (42 out of the 45) had talked to someone about their parent's alcohol problem, and they usually talked to more than one (the mean number of people talked to about the alcohol problem was 3.1 (SD 1.65), with a range of 1-7 people). These people included the young person's mother (in 19 cases), their father (in 13 cases), the step-father (2 cases), a sister (7), a brother (8), a grandparent (5), a friend (26 cases), and various professionals (a teacher (4), a sports coach (1), a family doctor (3)). The young people told us that talking to each of these people was almost always helpful.

Similarly, most (17 out of the 23) of the young people who experienced domestic violence in the home talked to people about it. Again these people included their mother (10), father (3), step-father (1), sister (4), brother (3), grandparent (4), friend (7), to an occasional professional (a teacher (1) and a family doctor (1)). Again, people tended to talk to more than one person about the domestic violence (between 1 and 7 people, mean 2.8, SD 1.75), and again the young people told us that talking to each of these people was generally helpful.

Some of the things that young people said to us about this were:
"With one person I talk to – what I like is that she is understanding, she can see both sides of the situation and is fair in what she says." Lots of people said positive things about their mothers or fathers (if they did not have the alcohol problem), including *"She doesn't just tell me to 'get on with it' but she helps in a practical way. She also gives money ... and is just a mum!" "If I have a problem, my mum will come and speak to me; if I have fallen out with someone, my mum listens to me. My mum tells me that she is here and that I can speak to her." "My father loves me … he reassures me that it's not my fault … we have fun. We talk about everything and anything. We talk about my mum's alcohol misuse, and he cheers me up if there is a problem*

or a fight with my mum." "He (Dad) listens to everything I've got to say and is concerned about me. He asked me to go and live with him because he was concerned about my safety. He makes me happy."

5.5.3 What has helped in the past

21 out of the 45 (47%) children and young people told us about things had helped them in the past, besides talking to the people described above.

Many said that they had needed to 'learn from experience': *"I learnt by experience – by having little arguments, I have learnt that I can get over things. The counsellor was not helpful. But now I sit down with my family and sort things out." "I talk to my older brother and sister – and I can stay with them if I want to." "I talked with my sister – we had the same point of view, we exchanged views and came to the conclusion that alcohol was to blame and not ourselves." "I write my diary." "I just get on with it: there are others worse off than me!"*

It was quite common to hear that young people found that talking to people with similar experiences is helpful: *"Talking about it, especially with people who have had similar experiences with their families/parents."* Very occasionally, people mentioned utilising professional help: *"Support of youth welfare service, counselling in addiction prevention, psychologists, school social workers"*.

Others avoid the situation, literally or figuratively: *"I get out of the situation." "Moving out of my mother's place to stay with my stepfather: this improved the relationship and regular telephone calls did not create the same conflict and burden as when I was still living together with my mother." "My holiday – I got away from everything for 3 weeks with my Dad. It was great". "Listening to music." "Cuddling my cat, playing loud music, dancing in my room, writing poems, praying, going out until they have calmed down." "Staying with my grandparents and playing football: cause I am very good at it and while I am playing I do not think of anything else. I am quite happy after, at least for a while."* Sometimes the avoidance is itself damaging: *"By cutting myself. It took away the stress, let it all out. I felt good about it at the time."*

26 out of the 45 children and young people (58%) said that they knew of at least one person or place which they could go to, to get help and advice about problems in their family, or where they could talk to someone. However, many children could not name even one person or place, and most that could mentioned very few – usually groups for 'children of alcoholics', sometimes a school counsellor or a doctor or other friends and family. Some mentioned that they knew of a telephone helpline, but that they had not used it. Occasionally children said that they could also talk to their parent's therapist / counsellor / doctor. Very few, from only one or two countries, mentioned any specialist professional services for the children of problem drinkers.

5.5.4 What would have helped in the past

The young people also told us about the types of help they would have liked in the past to help them cope; and the types of help they would like now.

Many said that, in the past they would have liked to have spoken to someone from outside of the family: to talk to *"someone who really understands it and does not pretend as if it was normal."* Many also said that

they would have liked to talk with someone so that they could *"understand better why mum drinks and is so sad."* A variant on this was the wish that *"Maybe mother would have reacted/done something about it earlier"* or "*That my mother would have talked more with me about it and not look away/ignore it*." Yet another variant was: "*It would have been good if my father's family supported me and mum and encouraged dad to go for treatment. Instead they encouraged him to drink, by offering him beer whenever they met him.*"

Others said that they would have liked practical help: *"Help with looking after mum – especially when I was younger, for example when I had to carry mum home from the pub. Also, I needed easy access to support earlier on – I went on an AA camping trip once when I was younger and this was really helpful – 'talking to other kids who understand'."* Another girl said *"Maybe some sort of home care/supervision so that I would not have had to spend so much time alone with mother"*. Another variant was *"To be able to stay away from home for long periods of time"*.

5.5.5 Help in the present

In terms of the help wished for now, there was less need expressed (possibly because all or most of these young people's parents were currently in treatment, so the major stress was at least temporarily removed). Some had wishes which were more around their drinking parent than themselves: one said that his father was currently in treatment, but that *"after the therapy I would like my father to join a self-help group"*. Others did have wishes for themselves: some suggested support from a counsellor / therapist – *"It would be good to get support with the 'anger' thing." "I feel it would be good to get support at school – perhaps a counsellor at school – as soon as you mention 'alcohol', they pass it on – they can't get too involved, they don't know how to help."* Many others also wished for *"Someone to talk to who had experienced it."*

5.6 Resilience

Although it is the case that most of these children and young people found coping with these often very negative experiences of parental alcohol misuse and domestic abuse extremely difficult, and that around a third of them developed significant problems as a result of this upbringing, it is also the case that the majority of them did not develop such problems, and that many of them found that they were able to cope, especially by using some of the support mechanisms and people which they found that they could call upon.

It seems clear that this project, as well as providing evidence of the harms done to these children and young people who are brought up in these environments, also provides evidence of the resilience of some of these children, as demonstrated by their positive coping, their lack of development of problems, and their lack of engaging in high levels of drinking or drug misuse. Further analysis of the data available from these interviews will enable us to develop a greater understanding of what it was in such cases which enabled children in such problematic circumstances to become or remain resilient.

5.7 Overall summary

These children and young people report having lived under considerable **stress** for often long periods, having to deal with family and parental environments where there was serious alcohol misuse, and serious domestic abuse, frequently moving into family violence. They also reported signs of considerable **strain**:

quite considerable numbers (36% of the sample) reached 'Borderline Clinical' or 'Clinical' levels of problem on the Youth Self-Report (YSR 11-18), and many (29%) also have had contact with Mental Health services, either currently or in the past. They report using a wide range of **coping** strategies and tactics, and frequently use coping strategies which are the most effective ones, such as seeking social support, trying to sort the problem out as well as they could, distracting themselves and trying to control their feelings. Some less effective coping strategies were also used, especially wishful thinking. However, in general, young people found it terribly difficult to cope in very helpful ways, and often were left feeling extremely angry, frustrated, and very sad. There were a wide range of people from whom these young people gained **support**, mainly parents and friends. Nevertheless, most young people were able to tell us about ways in which they could have been offered more support in the past, and how that would have been extremely helpful and might have made coping with these problems a little better. It is also clear that, although many children did and do suffer considerable strain, others have been able to become or remain **resilient**. It is vital that a better understanding is gained of the processes which allowed that to occur.

6 Existing Policy Responses within Europe

Given these findings reported above, what is the existing policy response across the different EU countries, and across the EU as a whole, to the problems which beset children, young people and families in situations where there is co-existing alcohol misuse and domestic abuse within the home environment?

It is important to note that considerable confusion exists in relation to the word 'policy', confusion that was also apparent within the group of project partners[7]. This is primarily because the word 'policy' as such does not exist in a number of non-English languages (such as German, for example), and even when an understanding is reached about the area encompassed by 'policy', many confusions and questions remain: definitions and understanding of 'policy' are very different in each country; there is often no clear translation for the English word; it is not clear how global or specific a 'policy' is meant to be?; how should the goals of a policy be measured?; can there be different levels of 'policy' (organisational, regional, national, EU-wide)?; what is the difference between a policy and a strategy? Indeed, one of the project partners, Dr Alfred Uhl, has listed over a dozen different definitions of 'policy' in an internal document for this present project (Uhl, 2006); and from these he draws out some dimensions along which policy can differ, including principles versus goals, broad formulation versus specific, explicit versus implicit, declarations of intent versus bodies of regulation, and strategic overviews versus detailed action plans.

Nevertheless, the most important finding of this component of the current project is that when each of the ten partner countries was asked to attempt to locate (and if so provide examples of) policies (however the term 'policy' was defined) in relation to addressing both alcohol misuse and domestic abuse within the family, this proved to be a problematic exercise. Many methods were used by the different partner organisations to locate any policy concerned with the co-existence of alcohol and domestic violence. Methods used included internet searching, library searching, asking via national and regional networks, interviews with colleagues from national research or other centres, including people who lead national work on the prevention of harm to children who have parents with a psychiatric disorder, or an alcohol or drugs problem, and people from national social development organisations.

What emerged from this relatively 'random snapshot' is that in all of the partner countries, and on many levels, these two problems (alcohol misuse, domestic abuse) are still dealt with separately. In fact, in discussion between the expert group, all experts were unanimous that these two problems are still fundamentally viewed as being separate. It is not that organisations in the partner countries are unaware of the links between alcohol problems and violence. There are many instances of documents (at both national and regional levels) which include both these two topics of alcohol and domestic violence. Examples of such documents include one on the prevention of domestic violence across a region, another about child and adolescent welfare services, another on working with multi-problem families, another for police officers on undertaking a risk assessment. In many or most of these documents there is a clear recognition of the

[7] Some of the material in the following two paragraphs is based on an analysis, undertaken by Dr Alfred Uhl (Austria) and Mr Christoph Lagemann (Austria), of the collected policy examples provided by project partners.

relationship between alcohol and aggression/domestic violence, but none of them contained any policy statements (neither of the broad principles which individuals or organisations should follow in dealing with these combined problems, nor of any specific goals or detailed action plans). Similarly, with the interviews conducted by project partners with key individuals, whilst again there was full recognition of the relationship between alcohol and violence, no-one could point to any action plans, rules, specific laws etc.

It was remarked that one of the problems seemed to be the lack of collaboration between the different organisations involved (for instance between the police authorities and the institutes for addiction). They work towards different goals and have different responsibilities. Even though the different organisations involved do work together in some ways, it appears that, in none of the partner countries represented on this project, this joint work has not resulted in clear policy statements concerning the co-existence of alcohol and domestic violence.

In many countries (e.g. England, Malta) there are (or are soon to be) in existence National alcohol policies, but these do not make policy statements about the co-existence of alcohol misuse and domestic abuse. In other countries (e.g. Hungary) there are policies and sets of laws about violence in the family (and there are often other mentions of family violence as well), but these do not mention alcohol problems or misuse at all; and the proposal in Hungary to develop an alcohol policy barely mentions family aggression and violence.

Occasionally there are good practice guidelines for working with 'survivors and/or perpetrators of domestic violence who also use alcohol and drugs' (England provided an example of such a set of guidelines from one regional area within England), where the guidelines address the issue of domestic violence and how best to work with survivors and/or perpetrators who are also using drugs and alcohol. Such guidance is aimed at all those working with the issues of domestic violence and substance use and aims to inform and improve practice; but such guidelines are not policy statements as such, and do not lay out goals which are able to be evaluated or set out prescribed action plans. Similarly, the National Treatment Agency for Substance Misuse in England has issued a document specifying the 'Model of Care for Alcohol Misuse' which should be followed by treatment agencies helping people with alcohol problems. Although the impact on children and families, and the overlap with domestic violence, are not central to this document, it does acknowledge several times the need to assess for the impact of the alcohol misuse on children (and other family members). Further, it is acknowledged that domestic abuse is one of a range of complex and co-existing issues that must be assessed for and addressed. Again however it does not set out a policy framework within which this work should be undertaken.

Some Governments have made greater strides towards developing more comprehensive policies. The Finnish Government set out an Alcohol Programme (2004–2007) which includes three partial objectives for the prevention and reduction of the adverse effects of alcohol, one of which was to reduce the alcohol-induced adverse effects on the wellbeing of children and families; and strengthening the preventive activities against domestic violence was mentioned as one of the measures aiming at reducing these adverse effects on children and families. Coming from the violence end as opposed to the alcohol end, the Finnish Government has also developed a National Violence Prevention Programme which lists a number of

measures which aim at preventing the consequences of violence in Finland. The programme introduces a number of targeted measures against violence, including, among other things, reduction of alcohol-related violence and violence committed/suffered by children and young people. Under the latter, the Programme states: "The situations of families with a general risk for violence, as well as situations of children in high-risk families with violence and excessive alcohol use, are consistently intervened with necessary supportive measures." Similarly the Federal Ministry for Health and Social Security in Germany agreed to develop and implement ten guidelines for the improvement of the situation of children affected by parental addiction problems (which included alcohol related violence). Although these certainly are major steps in the right direction, it is not clear that these constitute policy statements nor do they lay out goals able to be evaluated nor set out prescribed action plans.

Given the lack, in any of the EU member states from which project partners participated, of a coherent alcohol policy which encompasses the effects of alcohol on the family and the impact of alcohol-related domestic violence on the family, it is not surprising that there is also no sign of a coherent policy within the EU as a whole, linking alcohol misuse and domestic abuse.

Although the EU did issue a 'Communication' in October 2006 from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, titled "An EU strategy to support Member States in reducing alcohol related harm" http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0625en01.pdf, and although this does list as a key priority the ' Protect(ion of) young people, children and the unborn child', the document makes no major policy statement and lays out no goals able to be evaluated nor any prescribed action plans.

7 Discussion and Conclusions

7.1 What has been learnt about children living with both alcohol problems and domestic abuse?

These children and young people report having lived under considerable **stress** for often long periods, having to deal with family and parental environments where there was serious alcohol misuse, and serious domestic abuse, frequently moving into family violence. The children and young people experienced a similar range of negative experiences in relation to their parent's drinking as has been commonly reported in the previous literature, over many years (Christensen, 2000; Cleaver et al, 1999; Gorin, 2004; Klein, 2005; Klein & Zobel, 2001; Velleman, 2004; Velleman & Orford, 1999; Velleman & Templeton, 2007). It can also be seen that these children reported a very large number of negative experiences (as measured by the revised Children of Alcoholics Screening Test) in relation to both paternal and maternal alcohol problems.

It is also clear from the Conflict Tactics Scales results and from other data reported above that children experienced considerable levels of violence and aggression, especially between their parents, but also sometimes involving them as well. In many of the cases where the violence involved the children too, it was considerable and resulted in significant effects. In many other cases, there was major psychological (instead of or as well as physical) aggression. It is important to emphasise that previous research has shown that sustained psychological aggression can also cause significant harm to children and young people; psychological aggression can be equally as damaging as physical violence. This present research, then, has shown that very considerable aggression and violence was reported by these children as going on in their parental homes as they were growing up. This again corroborates previous information (e.g. Klein & Zobel, 2001; Velleman & Orford, 1999).

The children and young people also reported signs of considerable **strain**: quite considerable numbers (36% of the sample) reached Borderline Clinical or actual Clinical levels of problem on the Youth Self-Report (YSR 11-18), and many (29%) also have had contact with Mental Health services, either currently or in the past. They report using a wide range of **coping** strategies and tactics, and frequently use coping strategies which are the most effective ones, such as seeking social support, trying to sort the problem out as well as they could, distracting themselves and trying to control their feelings. Some less effective coping strategies were also used, especially wishful thinking. However, in general, young people found it terribly difficult to cope in very helpful ways, and often were left feeling extremely angry, frustrated, and very sad. There were a wide range of people from whom these young people gained **support**, mainly family and friends. Nevertheless, most young people were able to tell us about ways in which they could have been offered more support in the past, and how that would have been extremely helpful and might have made coping with these problems a little better. It is also clear that, although many children did and do suffer considerable strain, others have been able to become or remain **resilient**.

What is also clear is that remarkably little focused help and support is available to help these children and young people. The results from this project show how important it is to develop guidelines to advance the practice of prevention and intervention in the area of alcohol problems and domestic abuse within the family. It is also vital that all political decisions, especially in the health, social and safety areas, must be made taking into account the child's perspective.

7.2 What has been learnt about undertaking research on these children, across Europe?

This was an extremely difficult project to undertake, for a number of reasons.

7.2.1 Recruitment

First, these children are 'hidden'. Because of the shame and fear associated with both parental alcohol problems and domestic abuse, the children affected usually keep the very existence of these problems secret, and hence usually live in very socially isolated situations. Even if they ostensibly have some or even considerable social contact, they are usually still psychologically isolated, because of the need to keep this secret. Usually people in their immediate environment do not know about their situation.

For all of these reasons, it is very difficult to reach them with empirical social research methods. Recruitment is very problematic. Few services exist for these children, so recruitment from children's services is problematic. Even if they attend children's services (due to a referral because of another problem such as their bad conduct or their psychological difficulties), the service usually does not know about their parental and family problem(s). Similarly, recruiting these children via any form of public advertising is very problematic: most EU countries require parental consent before providing ethical approval for research to be undertaken, and obviously it is almost impossible for children in these situations to openly ask their parents for written permission for them to be interviewed about the alcohol misuse and domestic abuse being shown by these same parents! Again recruiting via parents who themselves are already in treatment for their alcohol or domestic abuse problems means that a highly biased sample is forthcoming – only a very small proportion of parents with alcohol misuse and domestic abuse problems ever enter treatment. Even with this skewed group of parents, there are major problems. Treatment agencies, who invariably focus on the adult with the alcohol problem and not on the rest of the family, are often extremely wary about asking parents to take part on this type of research, for fear that the issues raised will lead the parent to relapse; and parents are equally wary, because they do not wish their children to discuss what has been going on at home and fear further involvement with or reprisal from social or child-welfare services. And the children themselves may find talking about these issues extraordinarily difficult, especially given that they have learnt over many years that they must not discuss such matters outside of the family, often under fear of major punishment from their violent parent. There are also further problems that arise when recruiting via parents in treatment, related to the extra workload that this frequently poses for staff: because they often did not have the relevant information in their files (such as whether the drinker lived with their children, how many children they had, how old were they, are they in contact with their children, etc), gathering this information was time consuming.

In the event, given all of these problems, it was decided to try to access children and young people via a parent who was actively engaged in treatment for their alcohol problem, or via a child who was engaged in a child-related treatment or counselling service. The problems outlined above, and other problems related to each stage of attempting to recruit children and young people into this project are listed in section 4.2.1, above. For all of the reasons listed, then, the sample investigated was not representative of the entire group of children from families with alcohol and addiction problems. The project partners in this study tried exceedingly hard to recruit from a wide range of sources, but for many of them this proved impossible, and most mainly or solely recruited from adult or child treatment services. Given the resources that the project had and the time and money available to the project partners, this was the best compromise; but future research must attempt to recruit more widely than we, despite our major efforts, were able to.

Whilst it is acknowledged that this sample is inevitably biased, nonetheless the data collected offered an invaluable insight into the lives of this sample of young people. The experience of undertaking the research has been invaluable learning for conducting other, similar, research, including accessing young people in other ways, especially where a parent may not be currently accessing help for their alcohol problem, and particularly where young people might be able to be accessed because of their experience of parental violence or abuse. Further, the project greatly helped those project partners who worked in countries where interview research with children on topics such as these is extremely rare: this provided a major awareness-raising and training for them which they have stated will proved immensely helpful in the future, with further projects. Finally, the production of the standardised interview schedule, translated into a variety of languages, is also a major resource for future research activity into this area.

7.2.2 Ethical and other approvals and Mandatory Reporting

The problems were not just in the recruitment of the children and young people. There were also many organisational barriers posed by the growing weight of ethical regulation and requirements for mandatory reporting.

Each of the participating project partners in each country needed to obtain various approvals before this project could be undertaken in that country. One important finding from this project was that the various European states have quite different ways of dealing with research on the topic of child welfare or research with children in general. For example, in some countries, the very fact that minors were being interviewed was itself problematic. As another example, whilst in some countries a previous history of threats to a child's well-being, which now no longer acutely exists, need not be reported to the state welfare services for young people, the rules in other countries state that any type of threat to a child's well-being, even if in the past, must be notified to the authorities by the researcher involved. In this respect it makes empirical studies very difficult as, despite the anonymity and confidentiality that is ensured by the research project, in those countries where this ruling obtains, parents must fear being reported to the authorities even if acts of violence no longer occur, and researchers can often feel that they are placed in an awkward position.

It was also the case that the ethical procedures in some countries led either to very long delays (which in some cases meant that that country could not participate), or to a refusal to allow the research to go ahead, despite the fact that this was EU-funded and European-wide research.

The situation in relation to Ethical Approvals which applied in the seven countries (all anonymised) where interviews either were undertaken or were planned although eventually they did not occur, are listed in Table 11.

Table 11: Ethical and other approvals needed in different (anonymised) participating countries

	Anonymised Country						
	1	2	3	4	5	6	7
A. Was an application needed; if so, was it to a committee external to the institution, or to an internal one?	**No** ethics approval needed.	**No** ethics approval needed.	Approval needed. **Internal** committee.	Approval needed. **Internal** committee.	Approval needed. **Internal** committee.	Approval needed. **External** committee.	Approval needed. **External** committee.
B. Has your institution ever applied for an ethical approval before?			Yes. Dozens: all handled as internal matters.	Yes, 5 times.	Yes, very many times.	Yes, very many times: in excess of 50 times in more than 10 years.	Yes, once.
C. Was your application immediately successful?	Yes	Yes	Yes	Yes	No	No	No
D. What was requested?					More details on the protocol.	A variety of further clarifications, in writing. A return to the Ethics Committee was needed on two subsequent occasions, due to changes made to the study methodology which required further approval.	A variety of major changes, including to raise the lower age limit to 14, to modify the informed consent form, to modify the data protection policy, etc.

	Anonymised Country						
	1	2	3	4	5	6	7
E. What were the major points of criticism or suggestions raised?			No criticisms from the committee, but one prospective partner was concerned with the level of post-interview support available for the children, and others were worried about whether parents would be willing to have their children interviewed, and about the impact the interview might have on the parent in treatment. These concerns eventually led to one partner withdrawing from the collaboration, and to others not asking any parent whose condition they estimated might be disturbed for access to their children.	Although approval was given, the committee was concerned about having only one parent give consent for their child to be interviewed. Although usually a signature is needed from only one parent, the ethics committee stated that this was different as it was about the whole family. They asked for agreement from both parents; but accepted a signature from one, if the other parent did not protest.	The ethics committee is more used to experimental research and did not understand this type of research. The agreed Project-wide documentation had to be adapted to their rules. They had some methodological queries, especially related with the sample size. The protocol also had to be adapted to clarify better various methodological aspects.	We needed to confirm that children would be interviewed on their own, to alter various documents (such as information sheets) so that they were much more explicit about what was involved and what kinds of questions would be asked, and to clarify what procedures we had in place should any difficulties or adverse events arise.	Because we have to report any kind of child abuse (or neglect), we had to contact only those families where this abuse has been already known by the child care authorities; we had to inform the parent(s) about it (i.e. it means the impossibility of data protection in this case). It meant the modification of the research design (where and how to contact) and the content of the information documents and of the informed consents (for parents and for the children).
F. How long did the application process take? What was the eventual outcome?			2 months (the Committee only meets quarterly).	1.5 months.	4-5 months	3 months	1.5 years. In all, 4 separate applications made, to different committees (at first to a local one, for the other times to the National committee, within the Department of Health), finally successful.

A key issue which emerged as part of the ethical application in some countries was **mandatory reporting**: what needed to be reported to child welfare or child protection institutions in different countries. Because the research was going to ask about violence and aggression, it was likely that children and young people would reveal information about this, and hence project partners needed to know if there was any mandatory system of informing specific authorities about what was revealed. Again this project found that the situation differed across the EU. For example, in one participating country, there is no mandatory reporting of child abuse, neither for professionals (e.g. social workers or psychologists) nor for general citizens. In fact, the opposite can be true: revealing information discussed within a professional encounter (e.g. between a doctor or psychologist and a client) can mean that the person 'violating secrecy' may be liable to prosecution. In another participating country, it is a mandatory duty for all professionals (doctors, psychologists, etc) to notify child protection authorities if information is discovered suggesting that a child is being abused, whatever the circumstances whereby that is discovered. If the child or young person is deemed competent to make an adult decision, then reporting is not mandatory against the child's wishes. If it is decided to report, and if the information comes from a young person, it is good professional practice to try to ensure that the child is in agreement that the information is to be reported. In yet another country, it is a requirement that all cases of child abuse which a child reveals, which are not already known about, must be reported to the police, and the parents must be informed that this has occurred.

Another issue which emerged is whether or not professionals involved in working with children and young people have to be **police checked**, to see if they have a previous criminal record related to children. In at least two of our participating countries, any professional associated with health or social care who works with under 18s must have a Criminal Records Check to ensure that nobody with a known criminal record relating to child abuse or related offences is allowed access to children. In other countries this was not only not required, it was seen as an invasion of privacy.

Yet a third issue which emerged in relation to different ethical and other requirements, as they impacted upon this project, was concerning **parental consent**. Again there were significant differences across different EU partner countries. In one country, it is the case that the written consent of both persons having the care and custody of the child is necessary for a minor to participate in an interview or questionnaire study; in practice this is usually not feasible and therefore not implemented. If only one signature is presented it is assumed that both persons having the care and custody of the child discussed the issue and agreed upon it. In another country, consent to interview a child is needed from only one parent, as long as they have parental responsibility. In yet another country, at least one Ethical Committees argued that, in situations where a child under the age of 14 is to be interviewed or examined, the parent(s) must be present. (However, it also seems to be the case that this process does not appear always to be followed, in that there are several medical situation where the parents are not present or they do not attend as they do not wish to be there.) In yet another country, the national Constitution offers constitutional protection to families, which enshrines the rights of families and the importance of parental consent. Amendments have been proposed which will specify more about the rights of the child, but these are still mere proposals. Full parental consent must be obtained before research is conducted with a teenager; and it can be difficult to obtain consent for such research from parents and from agencies such as treatment centres.

7.2.3 Results of the learning

The sections above have outlined some of the main problems which beset this project. The fact, however, that it was difficult to do this research does not mean that it should not be done! Often, the most problematic areas are exactly the ones that need the most examination, and this is certainly true in this case. This hidden group of children and young people is at great risk, and it is vital that we get to know and better understand how best to help these children, and also how it is that some of them appear to be resilient. If we could better understand resilience, we would be better able to assist those children who are not 'naturally' resilient, and would be able to develop vastly superior prevention and intervention tools for that work. Furthermore, it is important to stress that, although the interviews were long and covered many difficult topics, they went very well, a huge amount of extremely important information was collected, and the children and young people universally told us that this had been a valuable experience for them. This latter point is particularly important. The question was raised within ethics committees and also in project discussions that interviewing these children and young people about such problematic issues could potentially be very negative and might even be re-traumatising for the children. This was emphatically not the case. It may be because the interview schedule was so carefully developed, or because the interviewers selected to undertake the research were such good and empathic interviewers and were so well trained, but for whatever reason, the young people reported very positively about their experience, they rated the interviews very positively (as reported in 4.3.4), and were very thankful that, at last, people were taking an interest in them and their experiences.

A few conclusions and ideas about ethical, legal and regulatory issues can be drawn from this project:

- although the situation is clearly extremely different across the different countries of the EU, in some countries, obtaining ethical approval to undertake research on sensitive topics and with a potentially vulnerable group is both time-consuming and potentially very problematic;
- it was clear that across the present partner countries and participating organisations, undertaking the *same project* meant for some that no ethical clearance was needed, for others that it was needed and that this could be undertaken internally; and for yet others that an external committee would need to be approached;
- it is clear that, for some project partners, to participate in the research meant that they had to get separate ethical approval from every agency where the research was to be conducted;
- yet for others, who had a pre-existing board for granting such approvals, a situation arose whereby they could use that single approval as a demonstration that the project has been under ethical scrutiny and hence argue that separate approvals were not needed from every participating organisation or agency;
- it is clear that the preparation of an ethical application can be both time-consuming and problematic for partner organisations who have not done this before, or have done it only rarely;
- some partner organisations needed to consult with various experts; included among the experts consulted with were: a child psychologist, the director of a district child psychological service, a lawyer specialising in data protection, a medical doctor who works with families with alcohol and drug problems about the practice of handling of child abuse cases, a social worker about practical details, a bioethical expert, a Professor of Law.

- Although the process of developing an ethical application is time-consuming and will involve a great deal of paperwork, it is often a very useful and helpful process to go through: explicating in detail what the project involves often allows a research team to fully consider all the features of their study.
- It is also the case that many suggestions made by ethics committees can be very helpful, which help the research team to clarify some aspects of the study.
- Many ethics committees are very unused to the sorts of methods used in this project - detailed qualitative interviewing, working with children and young people, asking about potentially distressing issues, etc. It is the case that, by making such applications, the project has raised the awareness of these expert committees about family alcohol problems and family violence.
- Although some participating project partners had been aware from the very beginning of this project that securing ethical approval for any research would be necessary, time-consuming and a drain on resources, it was clear that several of the partner countries were *unaware* that such approvals would be needed, nor aware of the time needed to follow this process (because they were unused to undertaking research as such, or because their organisations or countries did not require such approvals). There is therefore major learning which can occur here for future such projects.

The differences in such things as research and ethical policies among EU Member States concerning examining family alcohol problems and family violence may also reveal that there are different cultural and moral approaches toward these family issues in the different member states.

A key recommendation from this project is that clarifying and standardising these procedures across Europe would greatly assist future research of this type.

7.3 What are the implications for policy and practice across Europe?[8]

The children and young people told us that they had rarely been offered help in their own right to deal with their parental alcohol misuse problems and domestic abuse.

It is clear that a variety of solutions and improvements are needed. But whose job is it to respond? We contend that it is all of ours:

- Government (via policy directives, service commissioning and resource allocation)
- Professionals/service providers (all health, social care, criminal justice and other front-line professionals to identify and intervene)
- Professional education
- Communities/public

This poses considerable challenges, at all of the policy, professional and services levels.

[8] These concluding comments draw upon the presentations made at the 2nd ENCARE Symposium at Bad Honnef in April 2007 by Professor Dr Michael Klein, Dr Sarah Galvani, and Professor Dr Richard Velleman, as well as utilising our own ideas.

In terms of Policy, there are many issues:

- At the International level, there is no co-ordinated approach to tackling the interrelationships between parental alcohol misuse and domestic abuse.
- It is also the case that the regulatory regimes concerning (for example) ethical approval, or parental consent for undertaking research with minors, are very different in the different EU countries. A greater level of co-ordination and standardisation of these procedures across Europe would greatly assist future research of this type.
- At the National level, in all of the 10 EU countries represented in this project, there still exist separate policy bases for substance misuse and domestic abuse, and in some countries there exists an equally large division between policy frameworks relating to alcohol and to drug problems. There is very little acknowledgement of the overlaps between these issues. The family is often absent from all of these sets of policies.
- It is also the case that National policy directives lead commissioners to commission these various services (which ought to be very interlinked) separately: hence there are few linkages between alcohol or drugs or domestic abuse services, or between children's or adults' services; and the family (as opposed to individuals who drink alcohol or use drugs or perpetrate abuse) is often absent from all of these services.
- Related to this, the structural separation of adult and children's services does not appear to be listening to the needs and wishes of families, nor to facilitate joint working.
- At the Agency level, again there are very few policies and procedures in place; and there is some evidence that, if they do exist; they are not followed. Similarly, there is a lack of monitoring in order to provide an evidence-base on which to develop services.

At the Professional and Service level, the challenges are that:

- There is too great a focus on a single issue within services, e.g. alcohol or drugs or domestic abuse
- There is too great a focus on an adult vs. a children focus, rather than both.
- There is a lack of partnership/multi-agency working in spite of policy requirements to do so
- Potential practice partners…
  - use different models of working, e.g. social vs. medical models of alcohol use
  - have different priorities and targets to meet
- Professionals and services have limited knowledge and confidence to deal with each issue (alcohol problems; domestic abuse), let alone a combination of the two.
- Furthermore, there is a lack of practice guidance – thus nothing is in place to support or encourage good practice when issues are identified.
- There is a lack of informed and knowledgeable supervision.
- Where joint working exists, challenges include information sharing, staff turnover, mutual trust and respect.

At the level of Communities and the Public, it is vital to recognise that:

- A major source of support for children in families with alcohol misuse and domestic violence are stable, close adults outside of the nuclear family
- Children often want to get help from people outside the family, as demonstrated again by the children in this research
- Lots of children and young people do manage to access help from these stable, close adults outside of the nuclear family, again as demonstrated by the children in this research
- And finally, such stable, close adults outside of the nuclear family, if they exist for these children and young people, are more accessible than are services.

There are many implications of this work and these results and ideas presented above. Some of the key solutions include:

- ChAPAPs need greater public and professional attention and support.
- The present knowledge (e.g. concerning risk and protective factors) must be applied, and be applied sufficiently early.
- The prevention and treatment approaches developed so far should be evaluated and in cases where there is good evidence, introduced to all EU-25 countries.
- There must be a solid and secure basis to finance prevention and intervention with ChAPAPs.
- The interventions must happen early, in a comprehensive and coordinated manner, they must be family-oriented, and must contain both addiction-specific and unspecific elements.
- General experts (GPs, teachers, child protection services) must be informed and trained for the special situation and needs of ChAPAPs.
- The resources of communities as sources of support should be explored.
- New community-based interventions should be developed.
- Communities need to be activated, to pay attention to these problems of alcohol misuse and domestic abuse, and to respond.
- Children also report that talking to others who have had the same or similar experiences or problems in their families is helpful. They seem to find if helpful to realise that they are not alone. There are clear implications here about improving access to existing and future groups which are created for ChAPAPs, and about supporting these groups and making them better know.

We further recommend:

- The development and production of comprehensive guidelines outlining comprehensive, evidence-based help and support for ChAPAPs.
- The manualisation of basic approaches (easy to apply, e.g. for nursery/kindergarten, single case work, schools, promotion of parental capacity, etc.)
- Better and clearer regulations for financing work with ChAPAPs
- Strengthening public awareness and continuous education of experts (general and specific)
- Broadening early intervention through better networking of institutions, and strengthening ways of early detection (including motivational interviewing with parents)

We suggest that the future should include: Policy

- **International level** – there is an urgent need for the European Commission and WHO Europe to develop and issue International guidance on the issue of the co-existence of alcohol and domestic abuse problems, and on how best to deal with these problems.
- **National level** – at this level there needs to be policy recognition of the overlap in all of their documents, including ones relating to children, substance use and domestic abuse, recognition of impact, and need to respond.
- **Agency level** – monitoring of both issues and co-existence; policies and procedures in place to support staff and service users

The future needs also to consider Services …

- Services need to respond more holistically – a single focus does not address complex needs
- Services need to join together to provide one single service or to develop formal and active partnerships with each other at all levels of the organisations, e.g. management and front-line staff
- It seems clear that systems that separate adult and children services are not helpful for families – there is a need to change this structures, or to designate mandated partnership working with shared goals.
- Partnership working between substance misuse and domestic abuse agencies is vital. In these partnerships it is imperative to:
  - Focus on similarities of models of working and how to overcome any barriers
  - Learn about, and respect, each other's priorities; devise a way of working together that will do this
  - Share specialist information and set up training exchanges to support learning and confidence in working with the 'other' issues
  - Joint working - agree confidentiality protocols; ensure clear lines of accountability to help continuity if staff leave, ongoing cross agency communication and mutual support to foster trust and respect
- Similarly, practice guidance is essential - clear practice guidance on how to assess for other issues, with a clear discussion on how to respond (including impact on children), when to refer on and how, how to record, who to consult with etc
- There also needs to be clarity that dealing with co-existing domestic abuse and parental alcohol problems it is part of doing one's own job well: it is not always somebody else's job!
- In order to facilitate all of this above, managers and supervisors need training on all issues and an awareness of the impact on staff; and they need to take leadership on the policy and on practice development.

… And the Community

- The community and the general public must share the responsibility for intervening then alcohol misuse and domestic abuse is observed.
- The resources of communities as sources of support need to be explored and mobilised.
- New community-based interventions must be developed.

- Communities need to be activated, to pay attention to these problems of alcohol misuse and domestic abuse, and to respond.

Conclusions

The results from this two-year project of research and practice show how important it is to develop guidelines to advance the practice of prevention and intervention in the area of alcohol and violence problems within the family. It is also vital that all political decisions, especially in the health, social and safety areas, must be made taking into account the child's perspective. Some suggestions for what these guidelines should include are:

- Treatment facilities for alcohol, drug or violence problems should be obliged to find out whether their clients have children, whether the children currently reside with the parent undergoing treatment and to what extent there have been any instances of violence in their previous history.
- In cases of need, the pertinent institutions should be in a position to offer family-related support or at least to provide information on it and to offer a specific parenting skills' programme.
- Even if the professionals cannot successfully address the parents' addiction problem, there should be sufficient opportunities for support and assistance available.
- Appropriate awareness must be developed by a wide range of professionals: help and support strategies are better than ignorance and neglect.
- The institutions involved must work together better and, with the consent of the families, must develop and co-ordinate the implementation of assistance and support programmes. There need to be agreed information sharing protocols, and agreed methods of joint working, within each European country.

It is relatively clear how professionals can help families to reduce risk, develop protective factors and promote resilience in young people.

The four key points are:

- It is relatively clear how professionals can help to modify the impact of parental substance misuse on children: they should help them to reduce risk, develop protective factors and promote resilience
- Practitioners CAN intervene, and the focus does not have to be on the substance misuse, but on providing necessary beneficial factors in children's lives
- Practitioners must not be sidetracked into focusing on the parents' problems: the focus must be on the child's needs and how to meet them
- The problem is, not enough practitioners actually DO this! Further work is needed to encourage and train professionals to use this knowledge to work in a more focused and integrated way, looking at the full range of a child's needs within a broader context.

It is to be hoped that the work within the ENCARE project is one way that will encourage practitioners to do this, and take on more responsibility for promoting resilience.

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[i] The Daphne Programme is a multiannual programme of community action on preventive measures to fight violence against children, young people and women. It grew out of the Daphne Initiative, which ran from 1997 to 1999 on an annual basis, and arose as part of the European Commission's response to growing concern about violence aimed against children, young people and women in Europe.

[ii] TAVIM is "Treatment of Alcohol-related Violence In Men". It is a multinational project which aims to develop, pilot and implement the cognitive-behavioural TAVIM-Treatment Programme Manual for the treatment of domestic aggression and violence of men with alcohol problems. The manual is designed for a group therapy setting. The project runs until March 2008 and is led by the Catholic University of Applied Sciences North Rhine-Westphalia, Cologne, Germany, Principal Investigators: Prof Dr Michael Klein, Ms Danielle Reuber (until 09/07) and Mrs Emily Semmann (until 03/07).

[iii] CHALVI is "CHildren dealing with ALcohol and VIolence within their family": its full title is "Family violence and substance misuse with special attention to a child's perspective". The project brings together 10 expert organisations from 8 EU countries, and aims to prevent and reduce harm inflicted on children by substance misuse related adult domestic violence, child abuse and neglect. The project vision is to reach a substantial proportion of professionals working with children in the partnering countries, to build up their awareness and capacity to empower children affected by domestic violence. The project runs until February 2008 and is led by A-Clinic Foundation, Helsinki, Finland, Principal Investigators: Mr Teuvo Peltoniemi and Mr Antti Järventaus.

[iv] ChAPAPs is "Reducing harm and building capacities for children affected by parental alcohol problems in Europe (ChAPAPs)". The overall aim of this project is to prevent harms caused by health inequalities due to/ related to parental alcohol use, amongst children and adolescents. New and comparable data will be obtained about children's and adolescents' health inequalities from 17 different European countries. These data will constitute the basis for the development of best practice manuals and recommendations which will help to facilitate the work of professionals working with children affected by parental alcohol problems (ChAPAPs). The project runs until September 2010 and is led by the Catholic University of Applied Sciences North Rhine-Westphalia, Cologne, Germany, Principal Investigators: Prof Dr Michael Klein, Mr Axel Budde and Ms Diana Moesgen.